



## DOCTOR OF CLINICAL PSYCHOLOGY (DCLINPSY)

### Doctorate in Clinical Psychology: Main Research Portfolio

**1) Risk and protective factors for psychological adjustment of children born with a cleft lip and/or palate and their families: A review of the literature; 2) What is helpful about attending an Alzheimer's café: does it do what it says on the tin?; 3) An investigation into the role of non-specific factors in Cognitive Behavioural Therapy: a naturalistic study.**

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**Research Portfolio Submitted in Part Fulfilment of the requirements for  
the Degree of Doctorate in Clinical Psychology**

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Doctorate in Clinical Psychology

University of Bath  
Department of Psychology

October 2014

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- Literature Review: Thank you to Julia and Tina at the South West Cleft Team who inspired the topic of my literature review and to Julia and Claire who read draft versions and commented on these.

Thank you



## **Abstracts**

### *Main Research Project*

Title: An investigation into the role of non-specific factors in Cognitive Behavioural Therapy: a naturalistic study

Abstract: There is limited research into the impact of non-specific factors on the outcome of Cognitive Behaviour Therapy (CBT). This current study aimed to investigate the relationship between client and therapist attachment styles and client interpersonal problems to the therapeutic relationship and symptom reduction over eight sessions of CBT. Seventeen therapist-client dyads were asked to complete measures of interpersonal problems, attachment style and report on the therapeutic relationship. Results showed that in this small sample there was a relationship between core alliance, as rated by clients, to reduction in symptoms of depression over the course of eight sessions of CBT ( $T_B=0.423$ ,  $p<0.05$ ) but not anxiety. Client level of confidence in relationships was negatively correlated with the reduction in anxiety symptoms over time ( $T_B=-.320$ ;  $p<0.05$ ). The level of difference in scores on a measure of 'confidence in relationships' between therapists and clients was found to be positively correlated to the level of reduction in anxiety scores over eight sessions ( $T_B=.0428$ ;  $p<0.05$ ) and negatively correlated to the therapist rated core alliance ( $T_B=-.428$ ,  $p<0.05$ ). These results indicate that the role of attachment styles in CBT warrants further investigation and both clinical and theoretical implications of these findings are discussed.

Key words: Cognitive Behaviour Therapy, therapeutic relationship, treatment outcomes, attachment, interpersonal problems

### *Service Improvement Project*

Title: What is helpful about attending an Alzheimer's café: does it do what it says on the tin?

Abstract: Alzheimer's Cafes were developed in 1997 in the Netherlands and have since been set up all over the world. They are a post-diagnostic support group for people with dementia and their families with an aim to reduce stigma

around having dementia. As yet there have been very few evaluations of these cafes. This project aimed to find out what family carers of people with dementia found helpful about attending one of two Alzheimer's cafes. Seven carers took part in a focus group and two were interviewed individually about what they found helpful about attending an Alzheimer's Café and what they thought could be improved on in the future. Results showed that people found the opportunities to socialise with others 'in the same boat' the most helpful aspect as well as meeting professionals outside of the clinic. The results of this study will enable the development of a questionnaire that can be used to continue to evaluate the café and the feedback provided used to guide future service development.

Key words: Alzheimer's Café, social support, dementia, service evaluation

### *Critical Literature Review*

Title: Risk and protective factors for psychological adjustment of children born with a cleft lip and/or palate and their families: A review of the literature

Abstract: Research suggests that around 30-40% of children born with a cleft lip and /or palate will develop psychological difficulties. Services supporting these individuals need to be able to identify those that might be vulnerable as early as possible so that preventative support can be offered. This review summarises findings from research studies looking at within-group differences in samples of children with a cleft and their families. Risk factors found included being male, experiencing bullying or having additional difficulties. Protective factors included satisfaction with appearance and social support. The methodological strengths and weaknesses of these studies are discussed along with implications of the findings for theory and clinical practice.

Key words: Cleft lip and/ or palate, protective factors, resilience, psychological adjustment

**Risk and protective factors for psychological adjustment of children born with a cleft lip and/or palate and their families: A review of the literature**

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**Author:** Corin Le Huray

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(see Appendix 1 for guidelines for authors)

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## **Abstract**

Research suggests that around 30-40% of children born with a cleft lip and /or palate will develop psychological difficulties. Services supporting these individuals need to be able to identify those that might be vulnerable as early as possible so that preventative support can be offered. This review summarises findings from research studies looking at within-group differences in samples of children with a cleft and their families. Risk factors found included being male, experiencing bullying or having additional difficulties. Protective factors included satisfaction with appearance and social support. The methodological strengths and weaknesses of these studies are discussed along with implications of the findings for theory and clinical practice.

## **Introduction**

Cleft lip and/ or palate (CL/P) is the most commonly occurring congenital abnormality and affects one in every 600-700 live births in the UK (World Health Organisation, 2003). Cleft types can vary and include cleft lip (CL), cleft palate only (CP), and cleft lip and palate (CLP). Some may have a submucous cleft (SMC) whereby there are abnormalities in the muscles or bone underneath the surface of the skin. Cleft lips are often diagnosed antenatally; however some clefts may not be diagnosed until birth or in the case of a submucous cleft even later. About 27% of children with CP will have it as part of a recognised syndrome and may have additional health problems and/or learning difficulties (Calzolari et al. 2004).

In the UK there has been an overhaul of cleft services following a report from the Clinical Standards Advisory Group (Sandy et al., 1998). Currently families are supported by a specialist cleft team and are reviewed up until the age of 15 or 20. Treatment paths vary but children will typically experience at least one surgical intervention in their first year and possible further surgery as they develop.

People born with CL/P may be vulnerable to developing psychological difficulties for a number of reasons. Firstly, those with a CL and some with a CP are likely to have to cope with looking visibly different from other people. They may also sound different, with one half of children born with a CP requiring speech therapy (Sandy et al., 1998). Finally, they will have to have at least one operation to correct the cleft and in some cases may require several surgical procedures as they get older. This involves several clinic appointments and time off school or work. As those with a cleft are more vulnerable to experiencing teeth decay, this also means more dental procedures and appointments (Hasslöf & Twetman, 2007).

Some studies show significant differences between groups of children with a cleft and control groups, or normative samples, on measures of anxiety (Ramstad, Ottem, & Shaw, 1995), depression (Hunt, Burden, Hepper, Stevenson, & Johnston, 2006), behavioural problems (Hunt et al., 2006) and low self-esteem (Sousa, Devare, & Ghanshani, 2009). However, these results

are not always consistent and other research has shown no difference between cleft samples and control groups, or normative samples, on level of behavioural difficulties (Tobiasen & Hiebert, 1984), employment or educational achievements (Ramstad et al., 1995) and level of self-esteem and anxiety (Hunt et al., 2006).

These inconsistencies could be due to methodological differences, such as the use of different samples, outcome measures and study designs. However, they could also be due to individual variation in the way that children and families adapt to being born with a cleft. This has already been investigated in two previous literature reviews (Hunt, Burden, Hepper, and Johnston, 2005; Klassen et al., 2012). Hunt et al., (2005) found that the majority of children with CL/P do not experience psychosocial problems; however a significant minority have difficulties with depression, anxiety, behavioural problems or low satisfaction with appearance. Both reviews concluded that the many different measurements of psychological outcomes, (Klassen et al., 2012) and the inconsistent methodologies and samples (Hunt et al., 2005) make it difficult to draw any firm conclusions on the psychosocial impact of having a cleft on children and families. Individual variations in psychological adjustment are worth investigating further for both theoretical and clinical reasons.

Theoretically, the study of individual variations in response to adverse events is important in developing a better understanding of the longitudinal development of psychological disorders. Developmental psychopathology models, such as the bioecological model of development (Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 2007), consider the interplay of many factors including genetics, environment and individual responses when trying to predict psychopathology. The bioecological model emphasises the importance of sustained patterns of reciprocal interactions between the child and its environment in activating genetic predispositions for resilience or coping and in driving development. Rutter (2006) argues that the investigation of risk and protective factors is a necessary prerequisite to developing these models as there is a lot of evidence that there are certain factors which, if present, will act in a summative manner to increase or decrease the risk of psychopathology in an individual.

Risk factors are defined as “conditions or variables associated with a lower likelihood of positive outcomes” with protective factors being the opposite (p.195; Jessor, Turbin & Costa, 1998). These factors act on several levels, representing both individual differences and differences in the systems around an individual, each of which may be more or less influential at different times (Bronfenbrenner, 1979). Several protective factors have been identified in the general population. These include individual factors such as intellectual ability, autonomy, self-reliance, easy temperament, sociability, communication skills and effective coping strategies (Prince-Embury & Saklofske, 2013). Also systemic factors such as family warmth, a close relationship with at least one caregiver, positive school experiences, good peer relationships and positive relationships with other adults (Prince-Embury & Saklofske, 2013).

It is likely that many of these factors will be applicable for children with a cleft, however there may also be additional factors such as appearance or cleft type that are important to consider. A better understanding of some of these risk and protective factors will allow clinicians to better identify individuals that may be vulnerable, to intervene earlier to improve their psychological adjustment and to also effectively target interventions to boost protective factors.

So far, only one review has begun to look into factors that could make a difference in how children adjust to having a cleft (Hunt et al., 2005). This review focused on age and cleft type. Hunt et al. (2005) argued that age did not, on the whole, appear to influence the occurrence of psychological difficulties. There were a few exceptions, for example conduct problems, which appear to increase as children get older. Also they found higher levels of dissatisfaction in facial appearance in early and late adolescence compared to young adults (Hunt et al., 2005). When considering the impact of cleft type on psychological adjustment, Hunt et al. (2005) found lower self-concept and satisfaction with appearance in those with a CL or CLP. They also argue that those with CP appear to have greater reported learning difficulties, lower rates of secure attachments and higher rates of anxiety and depression.

## *Aims*

This narrative literature review aims to investigate which risk and protective factors are related to psychological adjustment for children with a cleft and their families. Psychological adjustment is a broad term that can have different meanings. Seaton (2009) argues that psychological adjustment as a concept can be broken down into four main areas. These are the absence of psychological symptoms, adjustment as normality (being similar to the majority), the presence of positive factors such as wellbeing and high satisfaction with life, and finally adjustment as the individual's trait level of positive adaption to difficult circumstances including emotional intelligence and level of resilience. All four of these domains are important in reviewing research in this field. This review also aims to consider the strength of these findings based on the methodological characteristics of the studies included in this review.

## **Method**

### *Inclusion Criteria*

Articles were included if the clinical population studied only included people with CL/P and not other craniofacial anomalies and where factors impacting on psychological wellbeing were measured. Randomised controlled trials, longitudinal and cross-sectional studies with or without a control group, and retrospective studies were included. There was no restriction on age of participants or cleft type. Studies could be self-report or parental report and could involve validated or unvalidated questionnaires, interviews and/ or observations. The main outcome of the study had to be either a measure of psychological adjustment (anxiety, depression, self-esteem, behavioural difficulties) or a factor that has been established to be closely related to psychological wellbeing in the general population such as attachment, educational functioning, satisfaction with appearance or social support. These factors were chosen as they had been used in a previous systematic review looking at the impact of cleft type and age on outcomes for children with CL/P (Hunt et al., 2005). Studies which investigated the relationship between age and



cleft type only on adjustment were included if they were published after 2003 to avoid replication of this previous review.

### *Exclusion Criteria*

Literature reviews and purely qualitative studies were excluded along with case studies, unpublished dissertations and articles written in a language other than English. Studies that included children other than those with a cleft and where they were not analysed separately from the cleft group were screened out.

### *Search strategy*

Initially three databases were searched for relevant articles, APA PsycNET (consisting of PsycINFO from 1597-December 2013 and PSYCArticles 1894-December 2013), PubMed (1964- December 2013) and SCOPUS (1960 – December 2013). The following search terms were used:

- a) “cleft” AND “adjustment”;
- b) “cleft” AND “outcome”;
- c) “cleft” AND “attachment”;
- d) “cleft” AND “social support”;;
- e) “cleft” AND “appearance”;
- f) “cleft” AND “cognitive development”.

These search terms were chosen as they reflected both elements from the definition of adjustment provided by Seaton (2009) and search terms used by Hunt et al. (2005). They were considered to be broad enough to capture all the relevant studies. The titles and abstracts were scanned and those that appeared to meet the inclusion criteria were added to a database which allowed for duplicates to be removed. Full text was sourced for all the relevant articles and they were all read by the lead author. Additional articles were sourced from the reference sections of these articles and also from a reference database kept by the local cleft team. Details from each of these articles were entered into a spreadsheet including information on the number of participants, age range,

samples included, outcome measures, which factors were associated with outcomes, how samples were recruited and details about the measures used and who was asked to complete them.

There were 46 studies that were found to meet the eligibility criteria for this research. Of those, 3 studies used the same sample at different time points (Hentges et al., 2011; Murray et al., 2010; Murray et al., 2008) and two others shared a second sample (Berger & Dalton, 2009, 2011). 1 study was a randomised control trial, 36 were cross-sectional studies and 9 longitudinal. 3 were retrospective studies reviewing medical records. In 16 studies the only respondents were children or adults who had a cleft, 11 were based on parental responses only and 3 studies used observations by clinicians. The rest used a mixture of parent, child and in 2 studies teachers were also included. The studies were mainly questionnaire based, 3 were based on observations, 4 included interviews and 3 had a task which children were asked to complete. 27 included validated measures only, 7 used only unvalidated measures and 12 had a mixture of both. See Appendix 2 for a summary of each study.

## **Results**

This section has been organised to first consider risk then protective factors that have been found to be linked with psychological adjustment in children with a cleft.

### *Risk factors*

#### *Gender*

Research into this area has produced mixed results. Studies using validated measures of child behavioural difficulties such as the Strength and Difficulties Questionnaire (Berger & Dalton, 2011; Heller et al., 1985) and the Child Behavior Checklist (Collett, Cloonan, Speltz, Anderka, & Werler, 2012) indicate that boys tend to score higher on these measures compared to girls. These studies include a wide range of ages from 4-16 and sample sizes vary from 42 (Heller et al., 1985) to 134 (Berger & Dalton, 2011). Two studies used both parent and child report measures and the third parent report only (Heller et al., 1985). However, when compared to normative data, scores of both genders

tended to fall within normal ranges suggesting these differences are not clinically significant. The following studies found no differences in gender balance in groups identified as having high or low resilience (Feragen, Borge, & Rumsey, 2009) or low self-esteem (Kramer, Gruber, Fialka, Sinikovic, & Schliephake, 2008).

The differences in results could be down to the range of outcome measures used, as it appears that studies using similar outcome measures produce similar results. They could also be due to interactions between some of these risk factors; for example age and gender, or gender and cleft type. There is some evidence this may be the case. The following studies show effects of gender, but only within particular cleft types (Broder et al., 1994; Feragen & Borge, 2010) or age groups (Broder et al., 1994; Feragen & Borge, 2010; Richman & Millard, 1997). Leonard, Brust, Abrahams, and Sielaff (1991) found that adolescent girls and boys under 12 years old tended to have lower appearance related self-concepts compared to girls under 12 or adolescent boys. Richman and Millard (1997) found a similar pattern of results when looking at internalising and externalising behavioural difficulties. This suggests that at adolescent girls and younger boys may be particularly vulnerable.

Epidemiological research shows that different types of cleft are more or less prevalent in different gender groups. CLP is found to occur more often in males and CP in females (Nagase, Natsume, Kato, & Hayakawa, 2010). Therefore, research investigating the impact of gender or cleft type on psychological adjustment should be interpreted with this in mind.

### *Age*

There is some evidence that 10 year olds have been found to be more satisfied with their appearance when compared to 16-year olds and this is particularly the case for girls with visible clefts (Feragen & Borge, 2010). This study is based on a sample of 661, 10 and 16 year olds recruited from a clinical setting. Children and parental reports are collected and many of the questionnaires used are validated.

Baker, Owens, Stern & Willmot (2009) included a sample of 103 parents with children aged 0-18 and they found age to be a significant predictor of scores on

a Family Impact Scale, with families with younger children showing the greatest impact. Age was not found to impact on ratings of behavioural difficulties in 91 11-16 year olds (Berger & Dalton, 2011) or on psychological functioning in 160 8-21 year olds (Hunt, Burden, Hepper, Stevenson & Johnson, 2006).

#### *Cleft type*

In the last ten years, since the Hunt et al. (2005) review, there have been six studies comparing different cleft types. One study found that children with visible clefts reported lower satisfaction with appearance compared to those with non-visible clefts (Feragen, Kvaalem, Rumsey & Borge, 2010). Another found that children with CP report having higher levels of depressive symptoms, fewer close friendships and lower acceptance than children with CL or CL/P (Feragen, Kvaalem, Rumsey & Borge, 2010). Sank, Berk, Cooper & Marazita (2003) found lower ratings of perceived social support in mothers of children with CP compared to CL or CLP. Other research has indicated that parents of children with CL and CP showed less stress-related growth compared to parents of children with CLP (Baker, Owens, Stern & Willmot, 2009) and Feragen, Borge and Rumsey (2009) and Berger & Dalton (2011) found no impact of cleft type. One study in this review has shown no significant differences in attachment style between the different cleft types (Endriga, Speltz, Maris & Jones, 1998).

The mixture of research designs, outcome measures and results found means that no clear conclusions can be drawn regarding the relationship between cleft type and psychological adjustment. However, these results suggest that it is an important factor to consider and cleft type may interact with other risk factors to lead to poorer adjustment.

#### *Socioeconomic status*

Socio-economic status (SES) has been found to be significantly linked to oral health related QoL in Syrian children (Dak-Albab & Dashash, 2013) and to higher levels of separation anxiety in a sample of American children (Tyler, Wehby, Robbins, & Damiano, 2013). With lower SES linked to lower self-rated QoL and higher numbers of children experiencing separation anxiety. Dak-Albab & Dashash (2013) included a sample of 87 children aged 6-14 and used

parent and child reports. Groups were split into low, medium and high SES and compared to each other on one validated measure of social and emotional wellbeing. Tyler et al. (2013) asked 231 parents to complete one sub-scale from a validated measure of child anxiety and used multiple regressions to identify predictors of high separation anxiety, one of which was low SES. Even though there are just two studies in this review that investigated the relationship between low SES and psychological adjustment, they are both methodologically strong studies and this area warrants further investigation.

### *Early experiences*

There is limited evidence from studies included in this review that early experiences of some children with CL/P appear to make them more vulnerable to developing psychological difficulties as they grow up. Murray et al. (2010) found that those with insecure attachments (at 18 months) tended to have higher scores on child behaviour checklists at 7 years as measured by teachers, but not as measured by mothers. This longitudinal study involved 93 children who were followed up to age 7 and used validated measures. Speltz et al. (2000) in their observational study found that for 57 infants followed from 3-24 months, lower ratings of maternal teaching skills at 3 months predicted cognitive development at 24 months. Endriga et al. (1998) found that in their sample of 57 infants aged 3-12 months, attachment style was related to level of maternal sensitivity at 12 months in both CL and CLP groups. It is unclear whether these studies use the same sample or were just recruited through the same treatment centre.

### *Late palate repair*

Studies so far have not found any impact of the timing of initial lip or palate repairs on attachment (Koomen & Hoeksma, 1993; Murray et al., 2008; Slade, Emerson, & Freedlander, 1999). There is limited evidence that later palate surgery may impact on cognitive development (Murray et al., 2008). Hentges et al. (2011) followed up the same sample of 94 children and found that at age 7, IQ continued to be lower in the late repair group. However, these findings were not significant. The sample may have not been large enough to have the power necessary to detect a significant effect. These studies used validated measures

of infant development and the longitudinal design allowed an insight into the longer-term impact of late palate repair.

### *Systemic factors*

Six studies looked into the relationship between systemic factors and the child's psychological adjustment. Risk factors identified include higher levels of parenting stress at 2 years of age, which was correlated with number of reported behavioural problems at age 7 (Endriga, Jordan, and Speltz, 2003). Also, poorer parenting which was correlated with higher scores on the Child Behavior Checklist as measured by teachers, but not by parents (Murray et al., 2010). Poor maternal adjustment has been found to be related to poorer child adjustment (Berger & Dalton, 2009) and Tyler et al. (2013) found that higher levels of separation anxiety were linked to poorer maternal physical health. These studies are all correlational and many are cross-sectional, therefore it is hard to establish causality. It could be that poor child adjustment predicts increased parenting stress or poorer parenting, rather than the other way around. Endriga et al. (2003) conducted a methodologically sound longitudinal study, but results are based on a small sample of 31 children with a cleft so are not generalisable.

### *Experiences of bullying*

Experiencing harassment or negative comments from peers is likely to be related to psychological functioning. Hunt et al. (2006) asked 160 8-21 year olds, a wide age range, to complete validated measures of psychological wellbeing and a standardised interview rating their social functioning. They found that teasing was a significant predictor of poorer psychological functioning, more so than just having a CL/P. Berger and Dalton (2009) found that higher numbers of negative social experiences were related to higher scores on the Strengths and Difficulties Questionnaire. Similarly, Feragen et al. (2009) found that those who were in the high resilience group reported a lower frequency of being teased compared to those in the low resilience group in a sample of 268 10-year-olds in Norway. Peer harassment has also been linked to increased level of concern about appearance (Feragen & Borge, 2010). All these studies include large samples (when compared to other studies in this review) and use validated measures. The age ranges of the samples do vary,

however the results all indicate that experiencing bullying is a pertinent risk factor for children with a cleft.

#### *Cleft related impairments*

Some of the associated difficulties with having a cleft, for example with speech or eating, have also been found to be linked to poor psychological adjustment. Murray et al. (2010) found that children with more difficulties with communication, as rated by researchers and using a standardised measure, had higher scores on the Child Behavior Checklist as rated by teachers. Tyler et al. (2013) found that those with impairments in speaking and eating were more likely to also score above the clinical cut-off on measures of separation anxiety.

#### *Appearance*

Very few studies measured the link between physical appearance and psychological adjustment. Millar et al. (2013) used 3D imaging procedures to describe numerically the level of facial asymmetry and the level of luminance of the scar. This was the only study found that used objective ratings of appearance, however their results were inconsistent. They found that the level of visibility of scarring was significantly positively correlated with scores on measures of anxiety and self-esteem in the CLP group, but not in the CL group. No other research in this review found a link between ratings of attractiveness and psychological adjustment (Starr, 1980b; Murray et al., 2010). However, these were based on clinician's ratings of appearance and therefore results may not be as valid.

#### *Protective factors*

##### *Social support*

Four studies suggest that social support can help families and individuals adapt to having a cleft. Baker, Owens, Stern, and Willmot (2009) asked 103 parents of children attending a cleft clinic aged 0-18 to complete validated measures asking about social support, adjustment and psychological distress. They found that higher levels of social support, an approach coping style and type of cleft were related to parental positive adjustment. Perceived family support is related to level of adjustment of parents after the birth of a baby with a cleft (Bradbury & Hewison, 1994). However, this finding is based on a small and fairly

heterogeneous sample of 25 parents of children of all ages. Wu, Chao, Lo, Chen, and Noordhoff (2000) found that higher levels of social support were linked to better overall life adjustment for 101 teenagers with CL/P living in Taiwan.

Sank, Berk, Cooper, and Marazita (2003) found that 145 mothers of children aged 2-18 who were born with visible clefts reported higher levels of social support than those who had children with CP. Also, mothers of female children, who completed more years of education and those with fewer children, were more likely to report higher levels of social support. This was a questionnaire based cross-sectional study that used validated measures of depression and social support. Maternal depression was found to be linked to lower levels of social support.

These studies, although using a range of methodologies, all provide evidence for the importance of social support in helping parents to adapt to having a child with a cleft. Unfortunately, only one study involved the young people themselves (Wu et al., 2000) therefore it is hard to draw any firm conclusions on the role of social support as a protective factor for children. It should also be noted that it could be that those parents who have adjusted better to having a child with a cleft, seek more social support and are more socially active.

#### *Satisfaction with appearance*

Higher self-rated satisfaction with appearance has been found to be linked to lower levels of social introversion (Richman, 1983) as measured using the Minnesota Multiphasic Personality Inventory (MMPI). This study included 30 15-18 year olds who all had a history of speech difficulties and visible clefts. Satisfaction with appearance has also been found to be related to increased psychological resilience (Feragen et al., 2009), better psychological adjustment (Berger & Dalton, 2009; Thomas et al., 1997), more positive social experiences (Berger & Dalton, 2009) and lower levels of depression (Marcusson, Paulin, & Östrup, 2002). Ramstad et al. (1995) found that adults with a cleft who were more concerned about their appearance, dentition and speech had higher scores on measures of depression and anxiety.



All of these studies used samples of different ages. Those including children ranged from age 10 (Feragen et al., 2009) to 20 (Thomas et al., 1997). Two studies used adult samples (Ramstad et al., 1995; Marcusson et al., 2002). Many of these studies used validated measures of both satisfaction with appearance and psychological adjustment. The only one that did not was Ramstad et al. (1995) which used non-validated questions to assess for presence of depression and anxiety and any concerns about their facial appearance.

Parent's views on their child's appearance may also be important. Slifer et al. (2003) found that when parents rated higher concerns about the appearance of their children, the more positively children rated their QoL. This finding was unexpected and they argue this is because parents put in place positive strategies to help their child to cope if they perceive them as being more vulnerable. The sample used was small (n=34) with a wide age range from 8-16. They did use validated measures from multiple informants, both parents and children.

#### *Positive appraisal of the cleft*

It appears that individual appraisals of the cleft are also important when considering psychological outcomes. Cochrane and Slade (1999) found that in 51 adults with CLP or CL who rated the impact of the cleft on their lives as being more positive tended to have lower scores on validated measures of psychological distress, social distress and higher levels of satisfaction with their lives. However, this could reflect underlying personality characteristics that predispose them to think more favourably about the cleft.

### **Discussion**

Following a review of research into this area it appears that how families and individuals respond to having a cleft varies according to their individual circumstances. Although there are some mixed results, this literature review identifies several risk and protective factors that appear to be related to psychological adjustment. Risk factors which are strongly supported include being male, having low SES and experiencing bullying. Those that are less well supported at present include poor parenting, the presence of additional

impairments, cleft type, later palate repair and appearance. Protective factors include social support and satisfaction with appearance. A positive appraisal of the cleft was also identified as a protective factor, but is less well supported at present. Finally, age also appears to play an important role, with some risk factors appearing to be more influential at certain developmental stages. The main findings are discussed further below.

### *Demographic factors*

The findings of this review suggest that there may be developmental stages that make children more vulnerable and that this may vary according to gender. Results are inconclusive and because of the variety of outcome measures used and different age ranges included, it is hard to combine results together in a meaningful way. This fits in with findings by Richman, McCoy, Conrad, and Nopoulos (2012) who argue that psychological outcomes for children with CL/P are the result of an interplay of many factors and are impacted on by developmental stage, gender and diagnosis. Many other authors also suggest a developmental perspective is important (Broder et al., 1994; Collett & Speltz, 2007; Eliason, 1991).

Adolescence is likely to be a difficult time as this is when young people begin to form their own identity, rely more on peer feedback or support and may also be feeling more judged by others (Shaffer, 2009). It seems that adolescent girls tend to be less satisfied with their appearance (Broder et al., 1994; Feragen & Borge, 2010; Thomas et al., 1997) and have lower self-concepts (Leonard et al., 1991). These results might reflect gender differences in adolescents' appearance concerns with girls more concerned about overall appearance and boys about muscle weight (Jones & Crawford, 2006). It may also reflect the higher number of appearance related conversations that girls are thought to be involved in, which also impact on body image (Carlson Jones, 2004). For young people with a cleft there are other factors to consider. The growth of the jaw during adolescence increases visible differences in appearance that cannot be corrected surgically until the jaw has stopped growing. This means possible further surgery and orthodontic work in later adolescence and young adulthood.

Some of the research studies found that boys had higher scores on measures of behavioural difficulties compared to girls (Berger & Dalton, 2009, 2011; Collett et al., 2012; Heller et al., 1985). This reflects patterns seen in the general population, especially for externalising problems (Zahn-Waxler, 1993; Fergusson & Horwood, 2003). Zahn-Waxler (1993) argues that there may be several reasons why boys experience more externalising difficulties than girls. These include imitation and identification with same sex models, different play and learning environments, different patterns of reinforcement and punishment and variations in societal expectations of how boys and girls should behave. She also writes that some measures may not effectively pick up on particular behavioural difficulties in girls and therefore results may not be valid.

### *Satisfaction with appearance*

Subjective ratings of appearance and satisfaction with appearance appear to be important in individual psychological adjustment, but not actual appearance or visibility of scars. Only one study in the review found a link between anxiety and objective visibility of the scar (Millar et al., 2013). However, the other studies were potentially open to measurement bias (Millard & Richman, 2001; Richman & Millard, 1997; Tobiasen & Hiebert, 1993).

It appears that it is the individual's appraisal of their appearance that is more important, which fits in with cognitive and behavioral models of appearance anxiety (Cash, 2005; Thompson, 2012). These models argue that it is appearance related beliefs that determine psychological outcomes. One appearance related belief is 'body image evaluation' which is defined by Cash (2005) as the level of satisfaction with appearance based on the level of discrepancy between the perceived body image and our ideal image. If individuals rate their appearance as being closer to their ideal image then this improves their sense of self-worth. However, this relationship also depends on another variable 'body image investment' which is the level of importance placed on appearance by that individual to boost their self-worth.

Studies in this review support the argument that a better perception of appearance is linked to lower scores on measures of depression (Feragen, Kvaalem, Rumsey, & Borge, 2010), higher psychosocial resilience (Feragen et

al., 2009) and non-clinical level scores on personality inventories (Richman, 1983). Other studies looking at appearance have found better outcomes for children with a cleft when there is less discrepancy between self-rated appearance and clinician rated appearance (Richman, Holmes, & Eliason, 1985) and when adolescents rate their own appearance as being better than as rated by other adolescents (Tobiasen & Hiebert, 1993). There is no research, as yet, in this field which investigates the role of body image investment.

### *Social Support*

Perceived social support and feelings of social acceptance were found to be linked to positive outcomes and higher rates of peer harassment linked to poorer outcomes. This is supported by findings in the wider health literature (for a summary see Reblin & Uchino, 2008). Social support is also a recurring theme that emerges in qualitative research across different cultural groups. Adolescents in Thailand with CL/P said that social support was very important in helping them to cope (Chimruang et al., 2011). Wu et al. (2000) found that social support is an important factor in determining life adjustment for Taiwanese adolescents born with CL/P and Tiemens, Nicholas, and Forrest (2012) interviewed 7 Canadian adolescent girls who described the importance of friendships and having a supportive family in bolstering their self-esteem and helping them cope with teasing.

Models of stress and coping highlight the importance of social support acting as a buffer against some of the negative effects of stressful life situations (Wallander & Varni, 1992). It is argued that social support has a direct effect on regulating physiological stress responses and provides a sense of safety (Eisenberger, 2013).

### *Robustness of these findings*

The generalisability of these findings is limited as many of the studies in this review recruited participants from just one or two treatment centres and they are conducted in mainly Western countries. Research is often conducted by the staff teams treating these patients, which could potentially lead to a bias in results. Also, there is no information available on whether the families have

received additional support from services, in particular psychologists, in the past. Or about their treatment pathways, for example which operations have they had, did they receive speech and language therapy or do they have regular appointments with a cleft team.

Overall, there is a reliance on self-report measures and many studies rely on only one informant (n=27). Those that involve two or more informants often show significant differences between parent and child reports or parent and teacher reports. This has also been found in other research (Lavigne and Faier-Routman, 1992). Kazdin (1994) argues that collecting information from parents and children is important as they each measure different aspects of the problem. Child reports focus on the internal experience and parents report on the observable impact of their child's difficulties on general functioning.

Finally, it should be noted that very few studies acknowledged any theoretical underpinnings to their research. The only studies that did were Baker et al. (2009) and Berger & Dalton (2009; 2011). This means that interpretation of findings is on the whole based on clinical experience or intuition rather than being grounded in theory (Bronfenbrenner & Ceci, 1994).

### *Limitations*

This review only included published articles in English which might have limited the results and may leave it open to publication bias. There were a number of studies that appeared relevant and that had to be excluded as they were not in English. Also the selection of studies was not cross-checked by another researcher to ensure accuracy and inter-selector reliability; however decisions about whether to include or exclude an article were made in discussions between the lead and third author.

### *Theoretical implications*

The results of this review have several theoretical implications. Firstly, they show that factors that are linked to psychological adjustment in cleft populations are not unlike those found in general population. This means that models of psychological adjustment that have already been tested in other samples are likely to have some utility in this field. However, there are additional factors that

it would be helpful to consider such as cleft type, dental problems, communication difficulties or the presence of other physical health conditions.

Secondly, the results of this review can be used to guide future research and model development. The strongest findings from this review (based on methodologically sound studies and consistent findings) show that social support, demographic factors and satisfaction with appearance are important in psychological adjustment. However, these findings represent just a small part of the wider picture. As argued by Fergusson and Horwood (2003), risk and protective factors do not occur in isolation of each other. It is likely that many of the factors identified have a bidirectional relationship with psychological adjustment and are also related in some way to each other. In particular the role these factors play in determining psychological adjustment appears to be influenced by the age of the individual. All of these factors need to be taken into account before a clear picture can emerge about the role they each play in determining psychological outcomes.

### *Clinical implications*

For clinicians working in cleft teams, this review has several implications. Firstly it highlights the need to screen families that attend clinics for level of social support, any appearance concerns and any experiences of teasing and bullying. This screening could, along with some consideration of their age, gender and cleft type, help clinicians to target those individuals who might be most in need. It appears that younger boys, adolescent girls and those with low socioeconomic status or low social support should be considered to be potentially more vulnerable. Secondly, it also indicates several areas where interventions can be targeted. Helping families connect with local support services, for example, supporting children to learn ways to respond to bullying and also working with children and young people to help them challenge their thinking about their cleft and their appearance. One such intervention being trialled currently is a computer based Cognitive Behaviour Therapy programme for children with appearance anxiety being developed by the Appearance Research Collaboration.

### *Future research*

This review identified gaps in the current research literature and areas that are worth further investigation. One obvious gap in the current research base is studies looking into individual appraisals of the cleft and how this impacts on psychological adjustment. This could be guided by cognitive behavioural models of appearance, for example, and be used to develop CBT interventions for children with a cleft. It could also lead to an investigation into the relationship between parental beliefs about appearance and the cleft and child's appraisals of the cleft.

Future research should investigate further the relationship between cleft type, socioeconomic status, demographic factors and the child's level of social support on psychological adjustment. It is clear that future research also needs to be able to investigate some of the interactions between these risk and protective factors. One way to do this is to adopt research designs used in the wider developmental psychopathology field. Achenbach & Rescorla (2006) argue that research should use a multi-method, multi-informant approach. This could involve statistical approaches such as structural equation modelling or hierarchical linear modelling in order to be able to consider the interplay between different factors. Studies should also be longitudinal to factor in the effect of age and development and would need large samples in order to have sufficient power to conduct these statistical analyses and for results to be generalisable.

There were no studies in this review that met all of the above criteria, however cross-sectional and correlational research is a first step in this process (Rutter, 2006). One such prospective study is, however, currently being undertaken by The Cleft Collective which takes into account biological factors such as genetic vulnerabilities. Future research should also use standardised rating scales that have been developed or validated for use in this population.

### **Conclusion**

This review found 46 studies that investigated factors associated with outcomes in children with a cleft and their families. The nature of this research is that a

majority of the studies are correlational or cross-sectional and therefore causality cannot be established. There are also a wide number of outcome measures adopted. All of these factors, as well as inconsistencies in the results, mean that it is difficult to draw any firm conclusions. However it does appear that factors such as age, gender, level of social support, concerns about appearance and socioeconomic status are important considerations when trying to identify families and individuals that might be more vulnerable. Although some of these factors are predetermined, there are also areas where intervention may be beneficial. Although this review focused purely on psychological outcomes, cleft care is provided within a multi-disciplinary team using a holistic approach. Psychological factors have been found to be related physical growth (Coy, Speltz, Jones, Hill, & Omnell, 2000) in children with a cleft and also speech and communication plays a part in wellbeing (Turner et al., 1998). It is likely that there is also a link between dental health and psychological factors such as depression and anxiety. This has been found in studies of adults without a cleft (Okoro, Strine, Eke, Dhingra, & Balluz, 2012) but has not yet been studied in this population. It is important to keep in mind the interplay of medical, dental and speech difficulties in relationship to psychological adjustment and on the likely impact of good psychological adjustment on engagement with other aspects of cleft care.



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**What is helpful about attending an Alzheimer's café:  
does it do what it says on the tin?**

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## **Abstract**

Alzheimer's Cafes were developed in 1997 in the Netherlands and have since been set up all over the world. They are a post-diagnostic support group for people with dementia and their families with an aim to reduce stigma around having dementia. As yet there have been very few evaluations of these cafes. This project aimed to find out what family carers of people with dementia found helpful about attending one of two Alzheimer's cafes. Seven carers took part in a focus group and two were interviewed individually about what they found helpful about attending an Alzheimer's Café and what they thought could be improved on in the future. Results showed that people found the opportunities to socialise with others 'in the same boat' the most helpful aspect as well as meeting professionals outside of the clinic. The results of this study will enable the development of a questionnaire that can be used to continue to evaluate the café and the feedback provided used to guide future service development.

## Introduction

Caring for a family member with dementia is incredibly difficult. Research indicates that family carers have higher levels of depression and anxiety (Schulz & Martire, 2004), more physical health problems and are at a higher risk of mortality compared to control groups of non-carers (Schulz & Beach, 1999). This is not surprising considering the challenges this role can bring. Schulz & Martire (2004) propose a stress/health model which outlines primary stressors for carers including patient cognitive impairment, problematic behaviours, supporting the patient in daily care tasks and navigating the health care system. These can then lead to secondary stressors including the deterioration in the relationship, family conflict or financial difficulties. Stress is increased when caregivers appraise themselves as being unable to cope with these demands, which then impacts on their emotional and behavioural response and can lead to mortality or morbidity.

Schulz & Matire (2004) go on to describe a number of interventions to reduce carer stress including social support, information giving, skills training, counselling and improving communication with professionals. Social support appears to be particularly important for maintaining psychological wellbeing (Solomon, 2004). Salzer (2002) argues that the benefits of social support are that it enables people to learn from each other, share the lived experience of a condition, feel better through downward comparisons with others who may be worse off and allows opportunities to help others. Research also suggests that interventions targeting more than one area are more effective in reducing carer perceived burden and symptoms of anxiety and depression (Schulz et al., 2002; Brodaty, Green & Koschera, 2003). This is not just important for carers, as reducing carer stress also increases quality of life for the person with dementia too (Orgeta, Orrell, Hounscome & Woods, 2014).

One intervention designed to support people with dementia and their families is the Alzheimer's Café. The café was devised by Dr Bère Miesen in 1997 in order to enable people to meet together in a relaxed setting and talk about dementia (Miesen & Jones, 2004). He felt that talking about dementia rarely happened in

families and that by creating the right conditions it would enable families to share their experiences with others in similar position. The cafés follow a set structure which includes socialising, a live interview on an aspect of dementia, live music and refreshments. At each café there are a number of volunteers and health professionals available to circulate and answer any questions. This intervention would potentially intervene at many different levels, including providing information, increasing communication with professionals and increasing social support.

There are very few published studies evaluating Alzheimer's Cafes. Capus (2005) held a focus group with six carers and identified an overarching main theme of 'comparing experiences between participants' with four sub-themes within this. These included the relational changes in close family, the effects of dementia on the wider relational system, the effectiveness of available resources and the perception of the café as a safe space in which to 're-story' the experience of dementia. This study does provide a useful starting point to think about some of the benefits of the café but there is no information on how these themes were deducted from the raw data so it is hard to verify their conclusions.

Jones and Miesen (2011) outline a number of benefits of the cafés including creating a safe atmosphere, providing social support and helping individuals to come to terms with the consequences of this disease. They also talked about the benefits of giving attention, information and an increased sense of control to people who attend. This is based on feedback obtained from café attendees and inferred from growing attendance numbers.

Morrissey (2006) gives a reflective account of the development and evaluation of a couples' version of the Alzheimer's Café. In this reflection he briefly mentions an evaluation questionnaire which showed that communication and issues around living with dementia were the most helpful topics of conversation. He also describes some of the themes that arose in group discussion, including not feeling alone, exploring ways of dealing with difficult situations and dealing with change.

Dow, Haralambous, Hempton, Hunt, and Calleja (2011) carried out a thorough evaluation of the Australia Vic Memory Lane Cafés. They conducted focus groups and surveys with people with dementia, carers, staff members, service providers and also conducted direct observations of the cafés. They concluded that the cafés were achieving the aims of the service model but that improvements could still be made to improve access and service user involvement. The people attending the cafes reported that they enjoyed the cafe and felt they benefitted from social inclusion, peer support, information giving and access to professionals.

In Wiltshire, there are three Alzheimer's cafés, one of which has just started. People who have been through the local memory clinics and who have a diagnosis of dementia are given information about the cafés and invited to attend. The cafés are open to anyone who has dementia or supports someone with dementia. Some people might attend every month and others drop in and out. In most cases the carers attend with their family member; however there are some carers who attend alone as their family member has passed away or has become too unwell.

The cafés are run by Alzheimer's Support which is a local charitable organisation. This project focuses on the two cafes that have been running for over a year and will be referred to for the purposes of this research as 'Café 1' and 'Café 2'. Each café follows a slightly different format. Café 1 generally follows the set format outlined by Dr Bère Miesen and described above (summarised by Jones, 2010). Café 2 is different, in that it does not often have musicians or a live interview. Instead they have taster sessions of other activities (for example singing sessions) or a talk. There are also fewer health care professionals attending Café 2.

Alzheimer's Support wanted to find out what families find helpful about attending the cafés. As the Alzheimer's cafés are supported financially in part by the local council is it important for them to show that they are helpful in order to sustain funding. From a theoretical perspective, it would be interesting to see



if the benefits perceived by carers are similar to those proposed by Schulz & Matire (2004). It was decided to use a qualitative approach as this seemed the best way to explore this area further. Evaluating the effectiveness of the café would be difficult as many families also accessed other groups and activities which could all play a part in reducing caregiver stress. It would also be hard to establish a baseline or control group for both ethical and practical reasons.

This project aimed to investigate what carers find helpful about attending an Alzheimer's Café. In particular it aimed to find out whether the Wiltshire cafés are both meeting the aims set out by the charity when they were developed. These aims are for families to get information on dementia, meet others in the same position and have opportunities to talk about the emotional experiences involved in caring for someone with dementia. Finally, it aimed to find out if there are any changes that carers would like to see happen in the future to the café's. This research was approved by the University of Bath Research Ethics Committee.

## **Method**

In order to compare experiences between Café 1 and Café 2, two focus groups were planned each containing carers who attended one particular café. However, this was not possible for Café 2 as the members did not feel comfortable talking in front of a group and only one person volunteered. Therefore, one focus group and two individual interviews were conducted instead.

### *Participants*

Participants were adults aged 50 upwards who all attend one of the two cafés and are currently, or were previously, caring for a family member with dementia. Only carers were approached to take part as it was felt that it would be difficult to ensure that people with dementia had opportunities to put their views across in the focus groups. Also, carers might feel able to talk more openly without their spouse or parent being present.

Seven from Café 1 took part in the focus group (3 men and 4 women). Many of them were caring for a spouse who had dementia (n=5), one was caring for his mother and one had lost his wife to dementia but still attended the café. They had all been attending for at least 8 months but some had been attending Café 1 since it started around 3 ½ years ago (n=3). Two people from Café 2 agreed to be interviewed (1 man, 1 woman) both of whom were caring for their spouse who had dementia. Café 2 had been running for a shorter length of time so the two people who were interviewed had only attended the café 2 and 6 times respectively.

Participants were recruited by the lead author who attended cafés and asked guests if they would be willing to participate in a focus group discussion. The author addressed the whole group at the beginning of the café then circulated afterwards to ensure everyone had the option to take part. Those who agreed were contacted by letter confirming the date and time of the focus group. Participants were asked to complete a consent form prior to the group indicating they were happy for the group to be recorded and confirming they were consenting to take part.

### *Focus groups*

The focus group schedule was devised in line with guidance published by Krueger and Casey (2000). Questions were based on needs identified by the charity as well as previous research into this area.

The focus group consisted of a brief introduction to the aims of the group. Then participants were asked how long they had attended and what their expectations had been when they came to the first session. This led into a facilitated sixty minute discussion that was focused around what they found helpful about attending the café and what they would like to see change in the future. As part of this discussion participants were asked specifically to review each of the three aims of the café and talk about whether that aim was being met and if so how helpful they felt it was. The group was facilitated by the lead researcher and another researcher was present to take notes of the discussion.

The individual interviews followed the same structure and the same questions were asked.

The interviews and focus group were all transcribed and the lead author read through the transcripts and coded the main themes that arose. The method of analysis was based on the 'scissor and sort technique' described by Stewart, Shamdasani and Rook (2007) as this fits the level of analysis required for this study and was devised for use with focus groups. This technique involves the information being sorted into responses to the individual questions before being analysed. The responses are read through and coded separately to identify themes in the responses. A representative sample of quotes was examined by a second rater to see if they agreed with the initial analyses. Any disagreements were noted and verified with a third person.

#### *Attendance figures*

Information was also collected on attendance numbers for the two cafés over a 12 month period (July 2012-July 2013) and summarised using descriptive statistics.

## **Results**

#### *Attendance figures*

Attendance figures at each café over a period of twelve months were very similar. Café 1 had an average of 21 guests attending each evening and numbers ranging from 13 to 36. Café 2 had an average of 19 guests and number ranged from 9 to 27. As information on the number of carers and people with dementia was not collected from Café 1 until February 2013 and Café 2 until May 2013 it is not possible to compare these over the twelve month period. However, from May to July 2013 (over three cafés) the average percentage of people with dementia attending Café 1 was 40.7% with a range of 36-45%. For café 2 the average percentage was 45% with a range of 44-46%. The rest of the guests were carers or family members of the person with dementia.

For both café's the number of people who attended once and did not return over the same twelve month period was less than 5%. The number of people who attended three or more times in a period of twelve months was over 90% for both the cafes.

### *Helpful aspects of the cafés*

As the respondents from the two different cafes expressed similar views the information gathered from the focus group has been combined with the interviews and both are summarised together below. Any differences between the two cafes are highlighted.

Themes that arose from included 'social support', 'access to professionals', 'information giving' and the 'environment creating opportunities for social interactions'.

#### 1) Social support

Attendees of both cafes reported on the benefits of *"being in the company of like-minded people"*. They talked about how helpful it is to be in a social situation that is free from embarrassment and to be able to share ideas with each other. One lady said that:

*"people can actually say...I don't know what to expect about this is there anyone who has had this experience who can help?"* (Focus group, participant 7)

Another gentleman said:

*"talking amongst people who have got experiences with Alzheimer's is very, very helpful...you talk to people and you pick up what seems to be insignificant little tips but are quite major when you think about them...I certainly look forward to going to see people and getting ideas".* (Interview, participant 1)

He also said how it was reassuring to know that other people had gone through the same thing.

A few people talked about the loneliness that can come with caring for someone with dementia and for the dementia sufferer themselves. They said that attending the café helped to alleviate this:

*“the person with Alzheimer’s realises that there are many, many other people with Alzheimer’s and they are not on their own...it will become, and has become in some cases, something to look forward to where you are meeting people that you met before ”.* (Interview, participant 1)

One lady talked about the benefit of numbers of people getting together and the power this has for instigating change:

*“you know where to go to say look there are a dozen of us here and we’re all finding that it’s actually very bad”* (Focus group, participant 7)

Another benefit that was highlighted by one gentleman was helping the individual with dementia to maintain social skills and build confidence.

*“when people are first diagnosed with dementia...they become very introvert. Well going to the café helps being them out of their shell and that makes them socialise better as well”* (Interview, participant 1)

## 2) Access to professionals

Individuals in the focus group who attend Café 1 talked about how helpful it was to be able to talk to professionals in a different context. At Café 1 they often have a range of professionals there who either give a talk or just circulate around the tables during the social part of the evening. One gentleman said:

*“you actually get the chance to personally talk to them and that’s by far the best part of the parcel for me always”* (Focus group, participant 5)

Others felt that the question session afterwards was more valuable than the talk. They liked the opportunities to become more familiar with local professionals and to be able to meet ones they had not come across as yet. One lady said:

*“you see them in a professional context, but just to see them out of that is nice because you can get more familiar”.* (Focus group, participant 6)

### 3) Information giving

Those from Café 1 talked about how some talks were more helpful than others. They said that helpful talks were *“informative and easy to understand”* and tell you *“this is the situation, this is what you need to avoid and these are the things that you need to do”*. They talked about finding it helpful when talks have resonated with their own experiences:

*“I felt something at the end of it. It hit me. I remember those days of hitting your head against the wall”* (Focus group, participant 4)

*“he acknowledged that there is an emotional aspect to this situation which is not as much mentioned”* (Focus group, participant 7)

One person from Café 2 said that the café provided information about other groups which she found helpful. Both people from Café 2 did not feel they were learning anything more about dementia from attending the café.

### 4) The environment creating opportunities for social interactions

Many people talked about the welcome they received from volunteers and how they were made to feel accepted. One gentleman from Café 2 said:

*“the actual people running the course they make you feel accepted from the very second you put your foot in the door and that’s the nice thing about that”* (Interview, participant 1)

He also talked about the food as another ice breaker that leads into conversations with people on your table. This is another difference between the two cafes as Café 2 serves afternoon tea where food is placed at the centre of the table and shared together. Café 1 has a buffet or individual portions of food served to each person. However, many people felt more could be done to make people feel more comfortable and to encourage them to socialise.

#### *Does each café meet its aims?*

The café’s have three aims: to provide information on dementia, to allow people to talk about the emotional aspects of caring for someone with dementia or having dementia and to meet people in a similar position.

##### 1) Provide information about dementia

Many people said that they felt the cafés did not provide them with much information about dementia. The individuals from Café 1 felt that this need was met by the carer’s course also run by the same organisation. They felt that the talks were short and so information had to be basic, however some were still useful in particular those giving legal advice. One from Café 2 felt the same; the other had not attended the full carer’s course and said they would like to have more talks at Café 2 on what dementia is and what it can cause. It seemed that the usefulness of talks depended somewhat on how long that person had been attending the café for, with those who have been attending the longest having a lot of knowledge already.

##### 2) Sharing emotional aspects of their caring role

This differed between the two cafes. Those from Café 1 said that they felt that this happens *“in the dialogue, when around the tables at the end”* another said *“I think we do get some of that, but the long tables don’t facilitate it”*. They also talked about how helpful it was having talks that addressed these issues too.

Those who attended Café 2 both seemed to feel that this does not happen. One said that they would not want to talk about it anyway and another said:

*"I think that needs to be addressed because I don't think people realise...what I go through...it would be nice to have somebody there who can, I would say for me it's alright for you to feel you want to shout, it's alright for you to go off and cry, it's alright to feel how I'm feeling."* (Interview, participant 2)

### 3) Meet others in a similar position

Everyone, apart from one, seemed to be in agreement that this was something that happened at the cafes. One lady said *"That is very, very successful...very successful and very important"*. However, one lady felt that this was difficult due to the age differences between herself and others who attended the café and also that her husband did not have a clear diagnosis as yet. She found that this made it harder to relate to other people there.

### *Suggested changes for the future*

Below are some of the changes that were suggested by participants:

- 1) Extending the 'social' part of the café so that there is more time for people to share ideas and experiences. This was suggested by people from each café.
- 2) Increasing opportunities to talk about feelings. One person suggested extending a talk about the emotions associated with dementia to talking about experiences in small groups.
- 3) Those who attended Café 1 talked about the live music and how for some it made them unsure whether they should talk over it or not and made it difficult to hear conversations. Someone suggested having 'music evenings' where there was live music and on other evenings having a CD playing quietly in the background instead.
- 4) Many people talked about how it was hard to be with people that they did not know. There were many suggestions how to improve this including



volunteers making sure introductions were made and helping to start a conversation. Also mixing people up a bit as they said people who knew each other often sat together every session.

- 5) Having a follow-up to the talks, where they are told what they need to be doing themselves to take things further if necessary.
- 6) Those at Café 2 said making sure if there are visitors to the café, for example health professionals, that they have the chance to introduce themselves to everyone at the start.

## **Discussion**

This project had three main aims. Firstly to find out what a group of carers found helpful about attending one of two Wiltshire Alzheimer's cafés. Secondly to see whether the two different cafes met the aims set out by Alzheimer's Support even though they followed slightly different formats. The final aim was to explore what changes could be implemented to make the café's more helpful and to guide future service development.

From interviews and a focus group discussion, the main benefit for carers seemed to be the opportunities to socialise with other people who were in a similar position. This fits in with research showing links between social support and the positive impact it can have on carers' adaptation to their caring role (Haley, Levine, Brown, & Bartolucci, 1987; Haley et al., 1996). They talked about the various benefits of this including sharing ideas, decreasing their sense of isolation, maintaining social skills and having more power as a group to bring about change. They also talked about the comfort that is brought about by being in a social situation where everyone understands that their partner or parent has dementia.

Other helpful aspects included being able to talk to professionals in a different context and hear relevant information about legal matters or other local services. These findings are similar to those found by Dow et al. (2011) in Australia where carers found that the cafes increased carers social support, their access to professionals and provided them with information on dementia.

These findings also provide some support for the stress/health model (Schulz & Martire, 2004) whereby interventions that seek to increase communication with professionals, provide information on dementia and social support are perceived as being beneficial by carers in helping them feel less isolated and better informed.

The original aims set out by Alzheimer's Support were that the cafés should provide information on dementia, opportunities to talk to other people in the same position and to share emotional responses to being diagnosed with dementia or having a family member who has dementia. When comparing feedback between the two different cafes there were many similarities. Both cafés provided opportunities to access social support and both made guests feel both welcome and accepted. Café 1 seemed to provide more opportunities to talk about the emotional aspects of caring for someone with dementia and to talk informally with professionals. Both of which seemed to be valued by the focus group participants. The discussions around information giving were mixed, however one person felt that being given more information in Café 2 would be helpful.

The attendance figures indicate that both café's seem to attract a similar number of guests and that this number can fluctuate throughout the year. It would be interesting in the future to look for any patterns between advertised talks and the attendance figures to see which ones are more popular. Café 2 appeared to have a slightly higher percentage of people with dementia attending compared to Café 1. This could be because Café 2 holds more activities that are seen to be beneficial for people with dementia, for example chances to try 'singing for the brain' or 'movement for the mind'. Whereas Café 1 tends to have more talks or interviews that might be seen to benefit carers more. This was supported by discussions in the focus group where they focused on benefits for carers and felt that the café was for the carer rather than the person with dementia. Those interviewed from Café 2 talked more about benefits for the person with dementia too. Finally, it could also be that because Café 1 is more established there are people there who have since lost their

loved ones or whose family member's condition has progressed to a point where they are no longer able to attend themselves.

These results have many implications for the service. Firstly, it appears that both cafés bring opportunities for social interaction, but more could be done to encourage this including introducing people who are sat together, mixing up tables or using volunteers to facilitate conversations between families or couples. It appears that it would be helpful to include more information-giving talks or interviews in Cafe 2 as this ensures that attendees are getting information on dementia and opportunities to meet other professionals. It appears that many of them who come to this cafe do not attend the carer's courses, possibly for the same reason they did not want to attend a focus group discussion, so might not get that information elsewhere.

Another issue that was raised was the live music and whether this prevents conversation at times, although it was acknowledged that this is pleasant for people with dementia. With regard to sharing experiences with each other, this does happen, but could again be encouraged further by having smaller groups around tables or more talks where people share their own experiences or talk about common emotional reactions.

This research does have some limitations. Firstly, the findings only represent the views of a small group of people and for the case of Café 2 only two people agreed to be interviewed. Secondly, it might be that the feedback given in the focus group was impacted by a desire to conform to group opinion as they all knew each other in advance. It should also be noted that even though just the carers had been invited, some brought along their spouses too. They did not want to join in the group but were sat in the same room throughout the discussion. Finally, their feedback might also have been influenced by the prompt questions asking about whether the cafés met specific aims; however this was always done after they had been asked open questions about what they find helpful about attending the cafés.

This project could be extended further by developing a questionnaire for carers and one for people with dementia to complete using some of the themes identified here. This would enable the service to find out whether these views are shared by the other people who attend the cafés. Also, this would enable them to explore the benefits for people with dementia, as well as their carers. This was touched on in this study but it is important to seek the views of people with dementia too.

This project has afforded an insight into what it means to these carers to attend an Alzheimer's café and how valuable they are. One person said:

*"I perhaps wonder how I would have got on without them to be honest...it's a very worthwhile thing and we are very grateful for all that is done".* (Focus group, participant 4)

## **Dissemination**

These results have been shared with the manager of Alzheimer's Support and will be presented at the charity's next steering group meeting. They have agreed to provide an official response after this meeting. A lay summary (see Appendix 4) has been produced to circulate to guests attending the cafés as a way of feeding back the results to participants in the research.

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**An investigation into the role of non-specific factors in Cognitive Behavioural Therapy: a naturalistic study**

**Project:** Main Research Project

**Author:** Corin Le Huray

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## Abstract

There is limited research into the impact of non-specific factors on the outcome of Cognitive Behaviour Therapy (CBT). This current study aimed to investigate the relationship between client and therapist attachment styles and client interpersonal problems to the therapeutic relationship and symptom reduction over eight sessions of CBT. Seventeen therapist-client dyads were asked to complete measures of interpersonal problems, attachment style and report on the therapeutic relationship. Results showed that in this small sample there was a relationship between core alliance, as rated by clients, to reduction in symptoms of depression over the course of eight sessions of CBT ( $T_B=0.423$ ,  $p<0.05$ ) but not anxiety. Client level of confidence in relationships was negatively correlated with the reduction in anxiety symptoms over time ( $T_B=-.320$ ;  $p<0.05$ ). The level of difference in scores on a measure of 'confidence in relationships' between therapists and clients was found to be positively correlated to the level of reduction in anxiety scores over eight sessions ( $T_B=.0428$ ;  $p<0.05$ ) and negatively correlated to the therapist rated core alliance ( $T_B=-.428$ ,  $p<0.05$ ). These results indicate that the role of attachment styles in CBT warrants further investigation and both clinical and theoretical implications of these findings are discussed.

## **Introduction**

Cognitive Behaviour Therapy (CBT) has been shown to be an effective treatment for anxiety and depression (National Institute for Health and Care Excellence, 2009, 2011). However, research consistently shows that not everyone benefits from this treatment approach. Effect sizes vary depending on diagnosis (for a review see Butler, Chapman, Forman, & Beck, 2006). The number needed to treat (NNT) calculation, based on effect sizes for CBT for depression, indicates that only around one in every three people get better as a direct result of having CBT (Driessen & Hollon, 2010). In order to make CBT as effective as possible, for as many people as possible, it is important to investigate factors that might impact on treatment outcome.

Research investigating outcomes in psychotherapy, including CBT, have previously focused on specific and non-specific factors. Specific factors relate to the theoretical orientation of the therapist and particular techniques they use as part of this theoretical approach, for example the use of cognitive restructuring in CBT. Non-specific factors relate to characteristics of the relationship between the therapist and client, for example the quality of the therapeutic relationship, which may also account for therapeutic change (Butler & Strupp, 1986). In the wider literature it has been proposed that there is a 'dodo bird effect' whereby the type of therapy offered is not important and that common factors across all therapies lead to symptom change (Luborsky et al., 2002; Messer & Wampold, 2002). However, many argue that this is not the case and that there is evidence that CBT is more effective than some other approaches for specific anxiety disorders and depression (DeRubeis & Crits-Christoph, 1998; Beutler, 2002; Chambless, 2002).

Research suggests that there is a 'moderate' association between the therapeutic relationship and treatment outcome in psychotherapy (Horvath & Symonds, 1991; Martin, Garske & Davies, 2000). In CBT, results are less consistent with some research finding a relationship between therapeutic relationship and outcome of treatment (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Krupnick et al., 1996; Zuroff & Blatt, 2006) and others not (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999). This

inconsistency is possibly due in part to methodological and sampling differences, including whether client or therapist reports are used and when in therapy the therapeutic relationship is measured (Stiles et al., 2004).

Bordin (1979) defines the therapeutic relationship as one that includes agreement on goals, assignments of tasks and the development of a bond. In psychodynamic approaches the therapeutic relationship is seen as the main agent for change and therapists seek out influences of past attachments on the therapeutic relationship and target these in therapy (Horvath, 2000). In CBT there is more of an emphasis on helping clients adopt specific skills to change their thinking and behaviour (Salkovskis, 2002). Hardy, Cahill, and Barkham (2007) argue that in CBT the therapeutic relationship provides a strong base upon which more specific therapeutic work can take place. By developing a therapeutic relationship, based on mutual trust and engagement, this provides the vehicle for the delivery of more targeted interventions. Therapist factors such as genuineness, empathy and warmth serve to facilitate this engagement (Beck, Rush, Shaw, & Emery, 1979).

In CBT there has been a lot of research conducted into specific factors that may account for symptom improvement and relatively little research into the role of non-specific factors (Martin, Garske, & Davis, 2000). One factor that has attracted a lot of wider research interest is the application of attachment theory to psychotherapy and investigation into the role that attachment styles of the client and therapist play in predicting psychotherapy outcomes (Dozier, Cue & Barnett, 1994; Horvath, 2002).

Bowlby (1978) argued that infants are predisposed to form bonds with their caregivers. Depending on how the caregiver reacts to this attachment seeking behaviour, this shapes the infant's subsequent attachment style. Dozier, Stovall, and Albus (1999) proposed that early experiences such as separation from caregiver, rejection or early loss lead to the development of an insecure internal working model where individuals hold negative beliefs about themselves and/ or other people. These internal working models impact on their ability to form meaningful relationships in adulthood (Mikulincer & Florian, 1998). Bartholomew & Horowitz (2004) argue that there are four attachment styles in adulthood:

secure attachment, characterised by positive beliefs about the self and others, and three insecure attachment styles, preoccupied, dismissing and fearful. Preoccupied attachment styles are characterised by negative beliefs about the self and high attachment anxiety and dismissing attachment styles by high attachment avoidance and negative beliefs about others. Fearful attachments are where people have negative beliefs about the self and others and high levels of both attachment anxiety and avoidance.

#### *Attachment and therapy outcomes*

Research into the links between attachment style and outcomes in psychotherapy suggests that the client's attachment style impacts on the early therapeutic relationship, with those with preoccupied attachment styles having lower therapeutic alliance ratings and those with secure attachments having the highest ratings (Eames & Roth, 2000). Reis and Grenyer (2004) found that fearful attachment styles negatively impacted on symptom reduction from supportive-expressive dynamic psychotherapy for depression but attachment styles were found not to be related to therapeutic relationship and the therapeutic relationship was not related to treatment outcome.

Alexander and Anderson (1994) describe each of the four attachment styles and how they might differentially present in therapy settings. They argue that those who are securely attached are able to make use of therapy and supportive relationships whereas those with dismissing styles are thought to be less likely to seek treatment, and if they do seek it, are less likely to benefit (Shorey & Snyder, 2006). This argument is supported by studies showing higher compliance with treatment in securely attached clients and less self-disclosure, rejection of treatment providers and poorer use of treatment in those with more dismissing styles (Dozier, 1990).

So far only two studies have investigated this in CBT (Hardy et al., 2001; McBride, Atkinson, Quilty, & Bagby, 2006). McBride et al. (2006) compared differences in outcomes between CBT and Interpersonal Psychotherapy (IPT) and found that those who were high in attachment avoidance (dismissing attachment style) tended to do better in CBT compared to IPT, and that there

were no differences between treatment outcomes for those with low attachment related anxiety and avoidance (secure attachments) or those high in attachment anxiety (preoccupied attachment style). They argue that as CBT does not place an emphasis on the therapeutic relationship it is a better treatment option for those who are avoidant of relationships and who have negative beliefs about the capacity of others to be available and supportive of them.

Only one study has compared different treatment effects within CBT. Hardy et al. (2001) found that participants who rated themselves as being more under-involved or avoidant of relationships showed less symptom reduction after treatment compared to those who were less avoidant. This relationship was in part mediated by the therapeutic relationship. They did not offer any theoretical explanations for their results. Neither of these studies included a measure of the level of security in relationships, focusing instead on insecure attachment styles.

It could be argued that individuals with insecure attachment styles have more interpersonal problems, as has been found to be the case by Horowitz, Rosenberg & Bartholomew (1993). These interpersonal problems are likely to be different depending on the individual's attachment style. A dismissing style could lead to problems opening up to or trusting others. A preoccupied attachment style could lead to being unduly influenced by other people and anxiety around ending relationships (Hardy et al., 2001). All of these factors could potentially cause difficulties in therapy, meaning that it is harder for therapists to develop an effective therapeutic relationship (Renner, 2012). It may also impact on treatment outcome (Horvath, 2002).

This argument is based on work by Horvath (2000) who proposed a model outlining the function of the therapeutic relationship in psychotherapy. He argues that the quality of the therapeutic relationship is predicted by the therapist's skills and interpersonal disposition and the client's interpersonal and intrapersonal factors, with the last three factors being the most important. DeRubeis, Brotman, and Gibbons (2005) also argue the importance of considering client characteristics, therapist characteristics and the interaction between the client and therapist in research into the therapeutic relationship.

The interaction between the attachment style of the therapist and client may also be important to consider in CBT. Therapist attachment representations have been found to be linked to therapeutic relationship (Black, Hardy, Turpin, & Parry, 2005) and therapy outcomes (Wongpakaran & Wongpakaran, 2012) with securely attached therapists showing better outcomes. The interaction between a client's and therapist's attachment style and the impact this has on therapeutic relationship and treatment outcomes has not yet been investigated in CBT. Research into other therapies suggests that client and therapist dyads that were different from each other appeared to do better (Dozier, Cue, & Barnett, 1994; Sauer, Lopez, & Gormley, 2003; Tyrrell, Dozier, Teague, & Fallot, 1999). However, there was no consistent pattern found and only speculation about the direct impact each attachment style had on therapeutic outcomes.

### *Summary*

Research into factors associated with treatment outcomes have focused on two areas: specific and non-specific factors. As yet there is limited research into the role of non-specific factors in CBT. Models examining the role of the therapeutic relationship argue the importance of considering client and therapist interpersonal factors. One such factor is the attachment style of the client and therapist which has been shown in previous research to be related to the therapeutic relationship and symptom reduction. It is argued that this relationship could be due to the number of interpersonal problems reported by people with insecure attachment styles which makes developing a therapeutic relationship more difficult.

There is evidence that the therapeutic relationship is related to symptom improvement in interpersonal psychotherapies with less consistent results emerging for CBT. This could be due to methodological factors or the perceived greater importance in interpersonal therapies of the therapeutic relationship as an agent of change.

This study aims to begin the process of exploring this further in a sample of clients receiving CBT in a clinical setting. This study aims to investigate the following research questions:

- 1) Is there a relationship between measures of therapeutic relationship measured at session eight and symptom reduction over eight sessions of CBT?
- 2) Is there a relationship between client attachment, therapeutic relationship (as reported by clients and therapists) and symptom reduction over eight sessions of CBT?
- 3) Is there a relationship between the number of interpersonal problems reported by clients, therapeutic relationship (as reported by clients and therapists) and symptom reduction over eight sessions of CBT?
- 4) Is there a relationship between differences in attachment style between the client and therapist, therapeutic relationship (as reported by clients and therapists) and symptom reduction over eight sessions of CBT?

Based on background research, it is hypothesised that a good therapeutic relationship, as reported by clients and therapists, will positively correlate with reduction in symptoms of anxiety and depression over eight sessions of CBT. Clients that report a high level of confidence in relationships (measure of secure attachment) will show greater symptom reduction over the course of therapy and report better relationships with their therapists. Measures of attachment avoidance and anxiety will be negatively correlated with the therapeutic relationship and symptom reduction. Level of interpersonal problems will also be negatively correlated with symptom reduction. The fourth research question is intended to be exploratory therefore no hypotheses are presented.

## **Method**

What follows is a description of the research conducted, however it should be noted that this was not the original planned methodology as intended at the start of the study (see Appendix 6). Due to severe difficulties recruiting both clients and therapists, the original study had to be adapted. Initial power calculations indicated that a sample of 21 dyads was needed to detect an effect size of 0.5 (based on Hardy et al., 2001) with power set at 0.8 and probability of error of 0.05. This effect size chosen was based on the lowest effect size found in previous research that investigated some of the same relationships as the

current study. However, only 17 were recruited. A post-hoc power calculation indicated that this sample had a power of 0.73 to detect an effect size of 0.5. This is a limitation of this study and will be discussed in more detail later.

### *Participants*

Therapist participants were CBT therapists, Counselling or Clinical Psychologists offering CBT in the NHS or in private practice. Eight therapists volunteered to take part in the research. A further two therapists completed therapist measures but their clients did not consent to take part, therefore they were excluded from the final analyses.

Client participants were 17 working age adults aged eighteen and over who had been referred for CBT. Although they were all experiencing symptoms of depression, this may not have been their presenting problem or the focus of therapy. All participants were screened for depression using the PHQ-9 and all had a score of 5 or over on the PHQ-9 at the time of assessment. Out of a total of 21 questionnaires sent out, 17 were returned which is a response rate of 81%.

### *Procedure*

Local NHS services were approached, including Improving Access to Psychological Therapies (IAPT) services and secondary care psychological therapy teams. Local therapists working privately and registered with the British Association of Behavioural and Cognitive Psychotherapy (BABCP) were also contacted and local student support teams offering CBT. The research was later branched out and contact was made with other regional services in Newcastle, Oxford, London and Guernsey. Around 60 therapists were contacted and a total of 10 therapists agreed to take part.

Therapists were then requested to approach clients who had attended six sessions of CBT, and who had an initial PHQ-9 score over 5, to find out if they were happy to take part in a research project. They were approached at session six to allow for questionnaires to be sent out before their eighth session. The clients were given the Participant Information Sheet and were asked for their consent to have their contact details passed to the lead researcher. Therapists



were asked to approach all clients on their caseloads who fit the criteria, rather than to target those that they felt were more likely to take part. A PHQ-9 score of 5 and over was used to ensure that participants were all experiencing symptoms of depression above the normal range. It also meant that the sample was as inclusive as possible so as to better represent the type of clients who are referred for CBT in a clinical setting. A cut-off of eight sessions was chosen to control for length of treatment (Shapiro et al., 2004) and length of time to establish the therapeutic relationship. It was also considered sufficient time to allow for symptom improvement.

Clients that agreed to take part were contacted by the lead researcher by phone and given the opportunity to ask any questions about the project before being sent the questionnaires in the post. A reminder text or email was sent out to them one week later and a second reminder about two weeks after this. Questionnaires were stapled together in a random order to reduce order effects.

The therapist questionnaires were sent out in the post or, where possible, were anonymised and sent via email using therapist and client identification numbers. These questionnaires were completed at around the same time as the client questionnaires (after eight sessions of CBT). In addition they were asked to supply the researcher with scores obtained from routine outcome measures. Both the clients and therapists provided written informed consent to take part in this research project (see Appendices 7 and 8 for client and therapist information sheets). Client participants received a £5 Amazon voucher to thank them for their time.

Full ethical approval was received from National Research Ethics Service Committee South West – Cornwall and Plymouth (see Appendices 9 and 10) and the Guernsey Health and Social Services Research Ethics Committee.

### *Measures*

#### *1) Symptom reduction*

Levels of depression and anxiety were measured using the Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001) and the Generalised Anxiety Disorder measure (GAD-7) (Spitzer, Kroenke, Williams, &

Lowe, 2006). See Appendix 11 for copies of these measures. The PHQ-9 is a 9-item questionnaire where respondents rate how often they have experienced a particular symptom of depression over the last two weeks. The scale for each item ranges from 0-3 where 0 indicates 'not at all, and 3 'nearly every day'. Scores range from 0-27 and scores over 5, 10, 15 and 20 indicate cut-offs for mild, moderate, moderate-severe and severe depression respectively. The GAD-7 is a 7-item questionnaire measuring level of generalised anxiety using a similar format to the PHQ-9. Scores range from 0-21 and 5, 10 and 15 are considered cut-offs for mild, moderate and severe anxiety.

The PHQ-9 has been found to have excellent test-retest reliability (Löwe, Unützer, Callahan, Perkins, & Kroenke, 2004) and good criterion, construct and external validity (Kroenke et al., 2001). The GAD-7 has good reliability and criterion, construct, factorial and procedural validity (Spitzer et al., 2006). Both are very straightforward to administer and score. Due to ethical considerations, it was decided to collect outcome scores from therapists as this reduced the amount of additional questionnaires that participants were required to complete.

## *2) Interpersonal problems*

Interpersonal problems were rated using the 32-item version of the Inventory of Interpersonal Problems devised by Barkham et al. (1996) (See Appendix 12). This scale consists of items that either end in '...too much' or begin 'it is hard for me to...' and each item is rated on a five point scale from 'not at all' to 'extremely'. The total mean score (ranging from 0-4) was used in this research as an indication of the scale of a client's interpersonal difficulties where a higher score indicates more difficulties. This scale has demonstrated adequate internal consistency in clinical and general population samples (Barkham et al., 1996) and McEvoy, Burgess, Page, Nathan, and Fursland (2013) found that each subscale demonstrated acceptable to excellent internal consistency in a clinical sample.

## *3) Attachment style*

This was measured using the Attachment Style Questionnaire (Feeney, Noller, & Hanrahan, 1994) and was chosen because it asks about attachments in

relationships generally, rather than asking about attachments solely in romantic relationships (see Appendix 13). It consists of five scales that measure 'confidence in relationships', 'preoccupied with relationships', 'need for approval', 'relationships as secondary' and 'discomfort with closeness'. Respondents are asked to show how much they agree with each of the items using a 6 point Likert scale which ranges from 1 'totally disagree' to 6 'totally agree'. It has been used in previous research and has established internal and test-retest reliability and validity (Feeney et al., 1994).

In the present research the three factor scoring system was adopted (Feeney et al., 1994) based on Hazan and Shaver's (1987) model of three attachment styles. This gives total scores of confidence in relationships, attachment anxiety (the sum of 'preoccupied with relationships' and 'need for approval') and attachment avoidance (the sum of 'relationships as secondary' and 'discomfort with closeness'). Confidence in relationships can range from 8-48 where a higher score indicates more confidence in relationships. Attachment anxiety can range from 15-90 and attachment avoidance from 17-102 where a higher score indicates higher levels of anxiety or avoidance. This scoring approach was chosen as previous research has focused on these three dimensions (McBride et al., 2006). This three factor solution has similar reliability and validity to the five factor solution (Feeney et al., 1994).

#### *4) Therapeutic relationship*

This was measured using the Agnew Relationship Measure (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) (see Appendix 14). This 28-item measure has a client and therapist version. Participants are asked to rate their responses on a seven point Likert scale anchored 'strongly disagree' to 'strongly agree'. The client and therapist are asked the same questions but to answer from their own point of view. For example, the client version includes "my therapist is supportive" and the therapist version says "I feel supportive". It measures five aspects of the working alliance including bond, partnership, openness, client initiative and confidence. It has strong convergent validity with

the Working Alliance Inventory (Stiles et al., 2002) and internal consistencies ranging from .77 to .87 (Agnew-Davies et al., 1998).

As used in previous research, a total core alliance mean score was calculated based on a mean score from the seventeen items that make up the bond, partnership and confidence scales (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Stiles et al., 2002; Stiles et al., 2004). This core alliance rating has convergent validity with other established measures of the therapeutic relationship (Stiles et al., 2002) and high internal consistency (Stiles et al., 2004). Scores range from 1-7 with higher scores indicating a stronger therapeutic relationship.

#### *5) Demographic information*

Demographic information was collected from all participants including age, gender, medication, length of depressive episode and number of previous episodes of depression (see Appendix 15).

#### *Statistical Analyses*

As the data was not normally distributed non-parametric statistical tests were used to firstly assess the change in PHQ-9 and GAD-7 scores over the course of therapy, then Kendall's Tau-B correlations were used to answer the research questions. The use of dyadic analysis was considered (Kenny, 2008), but this was felt to be inappropriate for this design considering the small sample size and that the individual therapists would in most cases appear in more than one dyad.

### **Results**

A total of 17 therapist-client dyads were included in the analyses below. Some therapists recruited more than one client.

#### *Client participants*

Client participants included 7 men and 10 women all of whom had a PHQ-9 score of five or over at the start of therapy. Nine were currently taking medication to manage their mood and sixteen had experienced previous

episodes of depression. Further demographic information can be found in Table 1.

The majority of clients were recruited from IAPT services (n=13) with a smaller number from private CBT therapists (n=2) and a specialist anxiety disorders clinic (n=2).

**Table 1:** Demographic information from client participants

Characteristic	Frequency within the sample
Gender <i>Male</i> <i>Female</i>	7 10
Age group <i>18-25</i> <i>26-35</i> <i>36-45</i> <i>45-55</i> <i>56-65</i>	6 4 2 4 1
Medication <i>Yes</i> <i>No</i> <i>Not known</i>	9 7 1
Length of current difficulties <i>Under 6 months</i> <i>6 months- 1 year</i> <i>Over a year</i>	0 2 15
Been depressed in the past <i>Yes</i> <i>No</i>	16 1
Previous episodes of depression <i>None</i> <i>Once</i> <i>Twice</i> <i>Three-five times</i> <i>More than five times</i>	1 5 3 0 8
Focus of treatment <i>Depression</i> <i>Anxiety</i> <i>Both</i>	3 12 2

### *Therapist participants*

A total of eleven therapists volunteered to take part and eight recruited clients into the research. The eight therapists were all female and their length of qualified practice ranged from less than a year to 12 years. See Table 2 for demographic information on the therapists. Four therapists recruited one client each, two recruited two, one recruited four and the final therapist recruited five clients.

**Table 2:** Demographic information from therapist participants

Characteristic	Frequency
Gender <i>Male</i> <i>Female</i>	0 8
Qualifications/Training <i>CBT therapist</i> <i>Clinical Psychologist</i> <i>Counselling psychologist</i>	5 3 0
Years of qualified experience <i>Less than one year</i> <i>Up to five years</i> <i>Five to 10 years</i> <i>Over 10 years</i> <i>Not known</i>	1 2 2 1 2
Service Setting <i>IAPT</i> <i>Private therapist</i> <i>Specialist CBT clinic</i>	5 1 2

### *Effectiveness of CBT*

A Related-Samples Wilcoxon Signed Rank Test indicated a significant reduction in PHQ-9 ( $Z=-2.868$ ,  $p<0.01$ ) and GAD-7 scores ( $Z=-3.109$ ,  $p<0.01$ ) over the course of eight therapy sessions. See Table 3 for median and range of pre and post therapy PHQ and GAD scores. A closer look at the results indicates that 15 participants showed improvement in PHQ-9 scores with two showing an increase in depressive symptoms. 15 showed a reduction in GAD-7 scores, one remained the same and 1 got worse.

**Table 3:** Summary of median scores and range for PHQ-9, GAD-7, IIP-32, ARM and ASQ.

	Median score	Range
PHQ-9 scores before therapy	12	22
PHQ-9 scores after therapy	5	25
GAD-7 scores before therapy	12	15
GAD-7 scores after therapy	6	17
Client core alliance	6.94	0.76
Therapist core alliance	6.17	1.12
IIP total mean score	1.34	2.53
Level of confidence in relationships - therapist	42	13
Level of confidence in relationships- client	48	5

### *Symptom reduction and the therapeutic relationship*

There was a significant positive correlation between change in depression scores over therapy and client related core therapeutic alliance ( $T_B=.423$ ,  $p<0.05$ ) indicating that those with higher core alliance ratings showed a greater improvement in depression symptoms over time (see Table 4). The same pattern was not seen for GAD scores or therapist rated core alliance, which in fact produced small negative correlation coefficients. As these negative correlations are small, it is assumed the results found are due to chance. Therapist and client rated core alliance were not found to significantly correlate with each other.

It should be noted that only 14 client participants completed the Agnew Relationship Measure as 3 were not returned. Also, it is likely that there was a ceiling effect on the client rated therapeutic alliance measure which may mask variance within the group studied. This is indicated by the high median score (6.94 out of a total of 7) and the small range in scores (0.76). A similar pattern was also found in the therapist's rated therapeutic alliance (median 6.17, range 1.12).

**Table 4:** Kendall's Tau-b correlations between core alliance ratings and change in scores on PHQ-9 and GAD-7 over time

	Change in PHQ-9 scores over eight sessions of CBT	Change in GAD-7 scores over eight sessions of CBT
Client rated therapeutic alliance	.423* p=.026	-.162 p=.228
Therapist rated therapeutic alliance	-.217 p=.121	-.070 p=.353

\*Correlation is significant at the 0.05 level

#### *Interpersonal problems and attachment*

No significant correlations were found between the IIP-32 total mean scores and changes in depression or anxiety symptoms over time, or between IIP-32 total mean scores and client and therapist ratings of the core alliance (Table 5).

There was a significant negative correlation between client confidence in relationships and change in GAD scores over time ( $T_B = -.320$ ;  $p < 0.05$ ), but not with PHQ scores. There were no significant correlations found between attachment anxiety and avoidance and symptom reduction or core alliance scores. Again the direction of some of these correlation coefficients were unexpected, in particular the differences between correlations with anxiety and depressive symptoms.



**Table 5** – Kendall’s Tau-b correlation coefficients and p-values for IIP-32 and client attachment measures with change in PHQ-9 and GAD-7 scores and therapist and client core alliance ratings.

	IIP mean score	Confidence in relationships (client)	Attachment anxiety (client)	Attachment avoidance (client)
Change in PHQ scores over time	.023 .450	-.023 .450	-.145 .215	-.076 .339
Change in GAD scores over time	.244 .091	-.320* .043	.008 .483	.146 .214
Client reported therapeutic alliance	-.048 .410	.049 .410	-.085 .346	-.109 .305
Therapist reported therapeutic alliance	-.137 .227	.304 .052	-.297 .053	-.122 .253

\*Correlation is significant at the 0.05 level

#### *Difference between attachment style of client and therapist*

In order to calculate the difference between therapist and client attachment styles, the client scores were deducted from the therapist scores for ‘confidence in relationships’ and the opposite for attachment anxiety and avoidance. This was because the therapist’s confidence in relationships scores tended in most cases (n=14) to be higher than their client’s and the opposite pattern was observed for differences in attachment avoidance and anxiety. Following this any negative values were transformed into positive scores so that a higher score on the resulting variable indicated a greater difference between therapist and client.

The level of difference in ‘confidence in relationship’ scores was found to be significantly negatively correlated with therapist rated core alliance ( $T_B = -.426$ ,  $p < 0.05$ ) and significantly positively correlated with change in anxiety symptoms over time ( $T_B = .428$ ,  $p < 0.05$ ). When therapist’s ‘confidence in relationships’

scores were increasingly different from those reported by their clients, therapists rated less positive therapeutic relationships and clients reported a greater reduction in anxiety symptoms over time. These findings will be discussed in more detail later. No other significant correlations were found to exist between the other variables (Table 6).

**Table 6:** Kendall's Tau-b correlation coefficients and p-values from correlations between level of difference between client and therapist attachment styles, therapeutic relationship and outcome in CBT

	Level of difference in confidence in relationship scores	Level of difference in attachment anxiety scores	Level of difference in attachment avoidance scores
Change in PHQ scores over time	.295 .113	.008 .967	.054 .771
Change in GAD scores over time	.428* .021	.000 1	-.038 .835
Client reported therapeutic alliance	.210 .332	.110 .608	.254 .233
Therapist reported therapeutic alliance	-.426* .022	-.353 .056	-.100 .588

\*Correlation is significant at the 0.05 level

## Discussion

Results show that in this sample of 17 client and therapist dyads, scores on measures of anxiety and depression did significantly reduce after eight sessions of CBT. Findings related to each research question are discussed further below.

### *Therapeutic alliance and symptom reduction*

The finding that higher client ratings of therapeutic alliance are related to a greater reduction in depressive symptoms over eight sessions of CBT is not

surprising. Several other studies have reported similar findings for CBT for depression (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Krupnick et al., 1996; Zuroff & Blatt, 2006) and this fits in with the argument that a genuine and warm therapeutic relationship provides a basis for a successful CBT intervention. However, this result should be interpreted cautiously as all the clients in this sample had a good relationship with their therapist as indicated by the small range of scores on the core alliance measure.

It was interesting that this finding was not observed with anxiety scores which had not yet been investigated in previous research. This could be because depression tends to involve more interpersonal difficulties compared to anxiety (Uhlmann, Beesdo-Baum, Becker, & Hoyer, 2010) and therefore the therapeutic relationship may be more important in CBT for depression. It could also be because anxiety treatments rely more on specific factors to bring about symptom change (DeRubeis & Crits-Christoph, 1998).

There were no significant relationships found between therapist rated core alliance and symptom change. Background research shows that therapist and client ratings of the therapeutic relationship are often not correlated with one another and that client ratings are considered to be more important in predicting outcomes (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004). This is because therapist ratings are thought to be based on their theoretical orientation and expectations derived from this whereas client ratings are based on their previous experiences of relationships with professionals (Horvath, 2000).

#### *Client attachment and interpersonal style*

Unlike Renner et al. (2012) this current study did not find any relationship between the client's interpersonal style and treatment outcomes or the therapeutic relationship. It lends some support to the argument raised by Hardy et al. (1998) that CBT therapists are able to adapt to their client's interpersonal style. It could be, however, that this relationship only occurs when there are higher levels of interpersonal difficulties present. Because the current study employed less stringent exclusion criteria, it meant that depressive symptoms at the start of treatment were lower compared to other studies and therefore the level of interpersonal difficulties may also have been lower. The different forms

of the IIP measure used in the Renner et al. (2012) study and the current study makes it difficult to compare the two samples in terms of their level of interpersonal difficulties.

The results also indicate that the higher the client rates their 'confidence in relationships' the less improvement is shown in anxiety symptoms over eight sessions of CBT. The 'confidence in relationships' scale is thought to measure the level of security in attachments and represents a positive view of the self and others (Feeney et al., 1994). These findings dispute the hypothesis that there would be a positive correlation between client 'confidence in relationships' and symptom reduction over eight sessions.

It could be that this finding is explained by a relationship between higher 'confidence in relationships' and lower rates of pre-treatment anxiety, which is in turn linked to lower levels of symptom reduction over time. Relationships between pre-treatment symptom severity and subsequent symptom improvement have been found in CBT for anxiety and depression (Gyani, Shafran, Layard, & Clark, 2011; Schindler, Hiller, & Witthoft, 2013). When clients have higher levels of anxiety pre-treatment there is more room for their scores to improve post-treatment. The same relationship may not have been observed for depression scores as the majority of the sample were treated for anxiety and research suggests that initial depression severity reduces treatment effectiveness for CBT for anxiety (Bower et al., 2013).

#### *Therapist and client attachment styles*

The level of difference in 'confidence in relationships' was positively correlated with reduction in anxiety symptoms over time. This indicates that the greater the differences between the therapist and client, the more effective the eight sessions of CBT were in reducing symptoms of anxiety. This has also been shown in other research (Tyrell et al., 1999) and they argue that therapists who have different attachment representations to their clients are better able to help their clients find ways to regulate their emotions and cope better with their emotional distress. This relationship could, however, also be explained by the link between client's level of 'confidence in relationships' and anxiety symptom reduction as it is likely that those dyads who had very different levels of

'confidence in relationships' included clients with lower 'confidence in relationship' scores.

Finally, differences in 'confidence in relationships' scores were negatively correlated with therapist rated core alliance. It could be that this was a chance result. However, it could also indicate that when therapists perceive their clients to be very different to them in terms of their general confidence in relationships and in their less positive views of themselves and others, that therapists find it harder to establish a working relationship. However, clients who are disposed anyway to think less positively about themselves and others did not rate these relationships any differently to other clients.

It should be noted that this sample and methodology differed from those used in much of the background research and this could also explain differences in findings. Firstly, even though the entire sample was experiencing depression this was not necessarily their main presenting problem and the majority had co-morbid anxiety problems too. Secondly, this study was conducted in a naturalistic setting and predominantly in a primary care setting too. This means that there were no strict inclusion or exclusion criteria and therapists did not receive any additional training. However, all therapists were all trained in CBT and received regular supervision. As noted previously, it also means that initial symptom severity was likely to be lower compared to other studies conducted in research or secondary care settings. Finally, this sample was monitored over only eight sessions of CBT which is fewer sessions compared to previous studies.

### *Limitations*

These results should be interpreted with some degree of caution. The small sample and sampling methods employed in the current study might have prevented other significant relationships that are present from being found. In order to achieve sufficient power, 21 therapist-client dyads needed to be recruited and only 17 took part. This meant that the statistical analyses were underpowered which threatens the validity of the results found. The study did

not control for therapist adherence to CBT strategies which could potentially have confounded the results.

The sample was self-selecting, clients had selected both to undertake CBT and to take part in this research, and therefore the sample may only include clients who felt they benefitted from therapy and therapists who feel confident in their abilities and themselves. Therapists may also have been more likely to approach clients who they felt they had a better rapport with, which may have biased the findings. This could have led to the observed small variance in therapeutic relationship scores. However, therapists were asked to approach all their clients that met the inclusion criteria and there were some clients who appeared to get worse over the course of therapy and who still rated themselves as having a good core alliance. Another limitation with the sample is that two therapists recruited nine clients between them, which represents a large proportion of the total sample. This could mean that data collected from just two therapists may have influenced the pattern of results found.

Another limitation is that this study relies on self-report measures which may be open to response bias. This is particularly the case for the therapists' measures of their attachment and measures of therapeutic relationship, where therapists and clients may have changed responses to make them more socially desirable. It is difficult to find other ways to measure attachment in therapists as they are likely to have knowledge of attachment research and so their responses may be influenced by this.

### *Theoretical implications*

These results do not provide any support for the argument that an insecure attachment style means that an individual has a high level of interpersonal problems and that this affects the therapeutic relationship and the outcome of CBT. It appeared that, in this sample, an insecure attachment style or interpersonal difficulties did not make the eight sessions of therapy any less effective. This is inconsistent with previous findings (Hardy et al., 2001; McBride et al., 2006) but perhaps consistent with the idea that attachment may be less important for CBT than compared to other therapies, as the therapeutic relationship is not used as the main agent of change.

Horvarth (2002) argues that both therapist and client characteristics are important in the development of the therapeutic relationship. This study found that client interpersonal factors, such as attachment style and interpersonal problems, were not related to the therapeutic relationship in CBT. These findings could indicate that there are other factors in CBT that are more important in developing a good therapeutic relationship such as therapist skill (Horvarth, 2002) or early symptom reduction (De Rubeis et al., 2005). It suggests that models developed based on other psychotherapies may not be relevant for explaining variance in outcomes in CBT.

### *Clinical implications*

The results of this study indicate that CBT is an effective approach regardless of the client's interpersonal and attachment style. In fact, those with a lower level of confidence in relationships appeared to show greater reductions in GAD-7 scores over eight sessions. The implications of these findings are that even clients who present with complex difficulties should be considered for CBT. It also highlights the need for therapists to be skilled at delivering specific interventions, particularly for CBT for anxiety.

There is some evidence from this project that when therapists and clients are different from each other, with regard to their attachment style, this actually leads to better outcomes over eight sessions of CBT for anxiety symptoms. Although this finding is very tentative, if it is supported in future research, there may be benefits in matching clients and therapists to ensure optimal effectiveness of CBT.

### **Conclusion**

Although the results should be interpreted with caution, due to the small sample size and limited range of core alliance scores, this study is the first naturalistic study to examine non-specific factors in CBT. The results appear to indicate that the therapeutic relationship, as rated by clients and therapists, is related to symptom change for depression but not for anxiety. In this sample, CBT is just as effective even when the client presents with higher levels of interpersonal

difficulties. There is some evidence that interactional factors between the therapist and client may account for some variance in the therapeutic relationship and treatment outcomes.

These results warrant further investigation. It would be interesting to replicate this study using a larger sample and with clients recruited from secondary care services to see if the same patterns emerge. Secondary care clients might be expected to have higher levels of initial symptomatology and more interpersonal problems. Future research should include ratings of the therapeutic alliance at different time points and investigate further the different effect of attachment on treatments for anxiety and depression. By completing measures at different time points it would allow some comparisons between those who complete treatment and those who drop out, as it could be that those who drop out do so because of the relationship with their therapists. It should be noted, however, that in this study recruiting therapist and client dyads has been extremely difficult and it is perhaps clear now why many of the background studies came about as part of a larger research trial. This issue should be taken into account when planning future research.



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## **Executive summary – Main Research Project**

Cognitive Behaviour Therapy (CBT) has been proven to be an effective treatment for anxiety and depression. However, studies show that not everyone who is offered CBT benefits from it. There has been a lot of research looking into factors which predict treatment outcome and these factors have been split into two categories, non-specific and specific factors. Non-specific factors are those which are common amongst all types of therapy and might include therapist characteristics or how well the therapist and client can work together (the therapeutic relationship). Specific factors are those which are unique to CBT and would not be used in other types of therapy. For CBT this might include techniques like cognitive restructuring where therapists guide their clients through a process of challenging their thoughts and beliefs to come up with more helpful alternatives.

There have been very few studies so far looking at the impact of non-specific factors on the effectiveness of CBT that have been based in a clinical rather than a research setting and have included CBT for anxiety as well as depression. This study aimed to investigate the impact of the therapeutic relationship on the reduction of symptoms of anxiety and depression over eight sessions of CBT.

It has been argued that the development of a good therapeutic relationship could be affected by client or therapist characteristics, and also the interaction between the client and therapist. This study also aimed to examine two factors that could be related to the development of a good therapeutic relationship, the client's interpersonal style and the similarity in attachment style between the therapist and client. These factors were chosen as there is research into other psychotherapies which indicates that they are important, however this has not yet been properly investigated in CBT.

Seventeen clients who were seen by eight therapists were recruited into this research. Clients were asked to complete measures asking about their interpersonal problems, attachment style and how easy they found working with their therapist. Therapists were asked to complete questionnaires asking about their attachment style and how they found working with that particular client.



Therapists also passed on scores obtained from measures they used routinely in their clinical practice to measure anxiety and depression.

Results showed that those clients who reported having better relationships with their therapists, had the most improvement in depressive symptoms over eight sessions of therapy. The same was not found for anxiety symptoms. Clients that had high confidence in relationships (a secure attachment style) reported having smaller reductions in anxiety symptoms compared to those with less confidence in relationships. This could be because those with higher confidence in relationships scores also had lower levels of anxiety starting treatment and therefore there was less room for the anxiety score to reduce further. The clients and therapists that were different from each other, in terms of their confidence in relationship scores, had a greater reduction in client symptoms of anxiety and a less effective therapeutic relationship as reported by the therapists.

These results tentatively support the argument that for CBT the non-specific factors, like the therapeutic relationship, are not key in explaining differences in treatment outcome. This finding is contrary to other research looking at other types of psychotherapy. There are some limitations to this study, one being the small sample size and the reliance on self-report measures. However, this study is naturalistic which means the sample is a better representation of the many different people who receive CBT in the NHS and privately. It also includes therapists that have been trained in CBT and are using this approach in their daily clinical practice. Further research might include a replication of this research in a larger sample and in secondary care psychological therapy services where clients might be expected to have severe depression and higher levels of interpersonal difficulties.

## **Connecting Narrative**

### *Service Improvement Project*

This project came about through an idea raised by a local clinician at the research fair. I have always been interested in working with families and was interested in the idea of the Alzheimer's Café which seeks to support people with Alzheimer's and their carers. I met with Paul Whitby and Rik Cheston (External supervisors) who had some ideas about what the project might involve but were keen for me to develop the research project myself following my own interests. I also met with the manager of Alzheimer's support, Anna, who told me what they were looking for and about some of the other evaluations they had used within their organisation.

Ailsa Russell, my academic supervisor, and I decided together to pursue the idea of using focus groups and to use a predominantly qualitative approach. I am interested in qualitative research and thought this would be the best way to approach this evaluation as there was little background literature and I felt that a questionnaire would give very little insight into what people found helpful. I had also never run a focus group and was looking forward to the opportunity to try this approach out.

The next stage was developing a plan for the focus group. To do this I drew on guidelines from published books on running focus groups and ran the draft plan and questions past Ailsa Russell and the manager at Alzheimer's Support to ensure the questions were those that they were interested in. Once this had been done, I worked on developing information sheets about the research which were also read by Ailsa and two members of the charity to ensure they made sense and were accessible to their client group.

I then applied for ethical approval through the university ethics committee and made some changes based on the feedback. The ethics committee expressed concern about people with dementia not being able to have their say in the group. Because of this, Ailsa and I decided to just include family members in the focus groups. However, this project was conceived by us and the charity as an initial step towards eventually enabling everyone who attended the café to

share their opinions. The themes identified from the focus group would be helpful in designing a brief questionnaire that could be completed by people with dementia. This approach had been successfully used in the past by the charity.

Once I had ethical approval I met with Ailsa again to discuss practicalities. Another charity worker had run focus groups in the past and I met with her to discuss some of the challenges and how she overcame them. I then attended the first Alzheimer's Café and managed to recruit 6 people to the project, a seventh contacted me via email afterwards in response to a notice on their newsletter.

The first focus group went ahead and nine people came along, two of whom were people with dementia who attended with their partners. The groups were co-facilitated by a research assistant who took notes and welcomed late arrivals. I then transcribed the focus group and set about organising the second one. However, when I attended the second café only one person volunteered to take part. I met with him and conducted an individual interview then attended the café again next month to try to recruit more participants. Only 1 other person agreed to take part and I met with her to conduct a second individual interview using the same questions used in the focus group.

Having transcribed the focus group and interviews, I set about looking for common themes in people's responses. Once this had been completed, Ailsa then looked at part of the transcript and checked my themes against her own. We managed to reach a shared understanding and I began writing up the project. The results were shared with Alzheimer's Support in the form of a written report and a summary sheet.

### *Critical Literature Review*

The topic for my literature review changed once I began my fifth placement with the cleft team. They mentioned that there was not much research in this area and I decided at that point that I wanted to focus on an area I had clinical experience in for my literature review. I had initially been interested in the impact of family factors on the outcomes for children with traumatic brain injury.

This idea developed into a curiosity about the factors that impact on the outcomes for children with a cleft. A brief look at the literature indicated that there were not many studies focusing on family factors so I decided to broaden this out. These ideas were discussed with my internal supervisor, Claire Lomax, and my clinical supervisor at that time, Julia Cadogan. Claire was happy for me to go ahead with this so I began conducting a literature search. The search terms were based on another literature review into a similar area and I followed guidelines on how to conduct a systematic review. Once this had been completed and written up, both Julia and Claire gave me feedback on the literature review and I made changes to it based on this.

### *Main Research Project*

This project went through a long development phase to become the project it is today. I initially met with Claire Lomax, my internal supervisor as I was interested in family factors that impact on the effectiveness of CBT and had begun by looking at the impact of expressed emotion, attachment and perceived criticism, factors which had come up from a literature review I conducted in this area. Paul Salkovskis helped me to get some ideas together. We discussed a mixture of questionnaires and a lab based mood induction and memory induction task. There were several variations discussed and Claire and I decided not to include a control group and eventually not to include a lab mood induction as we could not see the theoretical rationale for this. At this time I also met with Helen, a local psychologist with an interest in this area who helped me think about practical considerations and potential challenges.

I began completing the NHS ethics form and to look for potential services who might want to be involved. There was no take up within the NHS at this stage and Claire asked for support from Stephen Barton who eventually became an external consultant. He looked at my proposal and pointed me in the direction of another area of research where they had already investigated the areas I was interested in. He suggested I think about using the Inventory of Interpersonal Problems instead and focus on this and attachment. He also came up with the idea of asking both therapists and patients about their interpersonal styles. Over the next few months I refined my proposal and sought feedback from Claire and

Stephen on this until we were all happy with it. One of the course team had been approaching IAPT services on our behalf and through this had arranged a meeting for me and two other trainees with the lead of the Gloucester service. Following this, I applied for ethical approval through NHS ethics and for R&D approval. In the meantime I was contacting private therapists and had applied for ethical approval through the university ethics so I could recruit from non-NHS services. I also applied for ethical approval from the Guernsey ethics committee so I could recruit from Guernsey. NHS ethics had a number of questions I needed to respond to, which I did in a letter to them.

Once all the ethical approvals had been obtained, I was then able to recruit through NHS services. I approached all the local services and members of the course team also approached services they had worked in or had past colleagues working in, on my behalf. I met with Paul and Claire to discuss recruitment and at this point we decided to change the project to a cross-sectional one.

There had been a number of difficulties with recruitment. These included IAPT services being reluctant to sign up because of service changes and the number of questionnaires their clients are asked to complete already, secondary care services feeling that their clients would be too complex for CBT and this research and therapists forgetting to approach their clients. As it required both the client and therapist to sign up to the research there were some therapists who completed questionnaires about themselves and their clients that could not be used as the client had not given consent for their therapist to provide this information (n=2). There were also a number of clients who initially agreed to take part but did not then send back questionnaires (n=4) and those who were recruited to the initial prospective study but who did not send back the second set of questionnaires (n=3) therefore they did not complete client related therapeutic alliance measures.

I had to learn to be assertive with reminding therapists to approach their clients and made sure I sent out reminders to clients too who had been sent questionnaires. This was done with their agreement and the method of the reminder was discussed with them in the initial phone call. I also attended team

meetings to keep reminding therapists of the research project which seemed to work well.

Once a sufficient number had been recruited and I had exhausted all possible avenues for further recruitment the results were analysed and the project written up with help from Paul and Claire who each read through draft copies and advised me on statistical analyses.

### *Reflection*

Completing these research projects and my case studies has increased my confidence in conducting research and has given me an insight into how difficult it can be. However, I still feel that the overall process has been rewarding. I particularly enjoyed my SIP where I felt the results were useful for that service and helped them in some way. It was also rewarding to work with them to develop the project. It has been quite a personal achievement for me to complete all these projects.

I have learnt a lot throughout this process. I have learnt some things not to do when doing research, for example I would avoid conducting a project where I am recruiting through others. I have also learnt research skills, how to develop a project from scratch, how to utilise research supervision and how to apply for ethical approval. I have also learnt that even when the process of research feels like things are moving forward really slowly, despite a lot of hard work, I am able to keep going, albeit with a lot of support from others. I think that all of these factors will have an impact on the kind of clinical psychologist I will be in the future.

I have also enjoyed writing case studies. These both gave me an opportunity to try out single case experimental research and really cemented those theory-practice links.

When thinking about conducting research in the future, I feel some sense of trepidation. I know that the challenges I have faced over the last three years, I will have to face again. Hopefully I will continue to learn from my experiences. Once I start qualified practice I anticipate that some aspects of research might be easier. Conducting my literature review in an area I was working in at the

time was really helpful as it gave me a context to the review findings and enabled me to put some of my findings into practice myself. I found this process really rewarding and I am sure that this will be the case in the future. I will be working with other people who may share my interests and will have access to a client group for recruitment. However, finding time to conduct research will not be easy and I think I need to start by working on smaller projects, possibly like my SIP, or case studies in order to build my confidence. I have also learnt to ask for help along the way; my research supervision has been invaluable.

I am hoping to be able to submit some of my research projects for publication and have already submitted my literature review to the Clinical Child Psychology and Psychiatry journal.

## **Appendices**



**Appendix 1** Critical Literature Review: guidelines for authors from Clinical Child Psychology and Psychiatry

*The following extract is taken from the journal website*

*<http://www.uk.sagepub.com/journals/Journal200869#tabview=manuscriptSubmission> on 30<sup>th</sup> September 2014*

## **4. Manuscript style**

### **4.1 File types.**

Only electronic files conforming to the journal's guidelines will be accepted. Word DOC is the preferred format for the text and tables of your manuscript. Please also refer to additional guideline on submitting artwork [and supplemental files] below.

### **4.2 Journal Style**

Clinical Child Psychology and Psychiatry conforms to the SAGE house style. [Click here](#) to review guidelines on SAGE UK House Style

### **4.3 Reference Style**

Clinical Child Psychology and Psychiatry adheres to the APA reference style. [Click here](#) to review the guidelines on APA to ensure your manuscript conforms to this reference style.

### **4.4 Manuscript Preparation**

The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point.

#### **4.4.1 Preparation for blind peer review**

Wherever possible, authorship should not be revealed or suggested in the manuscript, so as to allow for blind peer review. When citing an author's own work, insert (author citation withheld for peer review) in place of the citation. The citations can be added after a manuscript is accepted for publication .

#### **4.4.2 Your Title, Keywords and Abstracts: Helping readers find your article online**

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on [How to Help Readers Find Your Article Online](#).

#### **4.4.3 Corresponding Author Contact details**

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

#### **4.4.4 Guidelines for submitting artwork, figures and other graphics**

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's [Manuscript Submission Guidelines](#).

Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

Figures, tables, etc.: should be numbered consecutively, carry descriptive captions and be clearly cited in the text. Keep them separate from the text itself, but indicate an approximate location on the relevant text page. Line diagrams should be presented as camera-ready copy on glossy paper (b/w, unless to be reproduced - by arrangement - in colour) and, if possible, on disk as EPS files (all fonts embedded) or TIFF files, 800 dpi - b/w only. For scanning, photographs should preferably be submitted as clear, glossy, unmounted b/w prints with a good range of contrast or on disk as TIFF files, 300 dpi.

#### **4.4.5 Guidelines for submitting supplemental files**

**Clinical Child Psychology and Psychiatry** does not currently accept supplemental files.

#### **4.4.6 English Language Editing services**

Non-English speaking authors who would like to refine their use of language in their manuscripts might consider using a professional editing service. Visit [English Language Editing Services](#) for further information.

**Appendix 2** Critical Literature Review: summary of the 46 studies that met the inclusion criteria

<b>Study</b>	<b>Participants</b>	<b>Outcome variables/ measures of adjustment</b>	<b>Possible risk factors related to adjustment <sup>1</sup></b>	<b>Type of study</b>	<b>Respondents</b>
Heller, Rafman, Zvagulis, and Pless (1985)	42, 4-13 year olds with CLP or CL	Missouri Child Behavior Checklist	Being male	Prospective study Questionnaire based	Parents
Richman and Millard (1997)	44, 4-12 year olds with CLP and CL	The Behavior Problem Checklist 1) Externalising problems 2) Internalising problems	1) Boys under 7 2) Girls over 7	Longitudinal study Questionnaire and clinician assessment	Parents Clinicians
Millar et al. (2013)	94, 10-year-olds with UCL and UCLP	1) Self-esteem 2) Depression 3) State and trait anxiety 4) Parental rated adjustment	1) & 3) More visible scar (UCLP only) 4) Greater luminance of scar	Cross-sectional Mainly questionnaire based	Parents Children
Broder, Smith, and Strauss (1994)	431, 5-18 year-olds with CL, CLP or CP	Forced choice questions: 1) satisfaction with appearance 2) problem solving 3) preference to play alone or with others 4) if they have as many friends as others	1) Boys with visible clefts, girls aged 5-9 with visible clefts and older girls in any group 2) CP	Cross-sectional Interview based	Children
Millard and Richman (2001)	65, 8-17 year olds with UCLP, BCLP or CP	1) Behaviour 2) Anxiety 3) Depression 4) Self-perception	2) & 3) CP (T&P) 3) BCLP and CP (C) 2), 3) & 4) being visibly different 2) & 3) CP, speech difficulties	Cross-sectional Questionnaire and Interview based	Children Parents Teachers

Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Despars et al. (2011)	22 mothers of children with a cleft aged 2-12 months with CL or CLP	1)Working Model of the Child Interview (2 months of age) 2) Impact of Event Scale (12 months)	1) Low PTSD scores	Longitudinal Interview and questionnaire	Parent
Koomen and Hoeksma (1993)	27, 9-18 month olds with CLP	1)Induced Stress at Home 2)Strange Situation 3)Perceived insecurity scale 4)Negative Behavioral Changes Scale	4) Late repair	Quasi-experimental, longitudinal study Observations and questionnaire	Parent Clinicians
Murray et al. (2008)	94 infants with CL or CLP, 2-18 months	1)Cognitive Development 2)Behaviour Problems 3)Attachment 4)Maternal depression	1) Lower rated mother-infant interactions 3) Being visibly different	Longitudinal – observations and questionnaires	Parent
Hentges et al. (2011)	93, 7-year-olds with CL or CLP (same sample as above)	1) Cognitive development (IQ, language and school achievements) 2)Wechsler Quick Test 3)Language ability	3) low maternal sensitivity at 2 months	Longitudinal, questionnaire, task and observation based	Parent and child
Murray et al. (2010)	93, 7-year-olds with CL or CLP (same sample as above)	1)Child Behaviour Checklist (T & P) 2)Child social interactions (observations of play time) 3)Self-concept 4)Representations of peer interactions (doll play task)	2) & 1) (T) Insecure attachment and poor parenting 1)More speech problems	Questionnaire, observations and tasks Longitudinal	Teacher, parent and child

Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Slade, Emerson, and Freedlander (1999)	Mothers of 33 infants born with CL/P aged 0-6 months	Maternal anxiety Maternal depression Self Perception Inventory Neonatal Perception Inventory Feelings of Attachment Scale Impact of Event Scale Interview about concerns	None identified	Longitudinal, questionnaire and semi-structure interview based	Parent
Andrews-Casal et al. (1998)	61 families with children who have CL or CLP aged 0.5 – 13 years	Parenting Stress Index Hollingshead Index of Social Position (SES measure) Reproductive plans	None identified	Questionnaire Cross-sectional	Parent
O'Hanlon, Camic, and Shearer (2012)	54 parents of children with CL/P. Mean age 12.	Ways of Coping Resilience Interpersonal Support Posttraumatic Growth Cleft-specific questionnaire	None identified	Questionnaire Cross-sectional	Parent
Baker, Owens, Stern, and Willmot (2009)	103 parents of children with CL/P aged 0-18	1)Adjustment 2)Psychological distress 3)Family Impact Scale	1)CL/CP Avoidance coping Less social support 2)Avoidance coping Low social support 3) Younger child Presence of other medical conditions Avoidance coping Low social support	Cross-sectional Questionnaire based	Parent

<b>Study</b>	<b>Participants</b>	<b>Outcome variables/ measures</b>	<b>Possible risk factors related to adjustment</b>	<b>Type of study</b>	<b>Respondents</b>
Bradbury and Hewison (1994)	25 parents of children with CP aged 11-28 months or 8-21 years	Parental adjustment	Less social support	Cross-sectional, questionnaire based	Parent
Sank, Berk, Cooper, and Marazita (2003)	145 mothers of children with CL/P aged 2-18	1) Perceived social support 2) Depression	1) Non-visible cleft, large family size, male child, lower maternal education, maternal depression 2) Less social support	Correlational study Questionnaire based	Parent
Berger and Dalton (2009)	134 children with CL/P aged 11-16 years and their parents (n=143)	1) Strengths and Difficulties Questionnaire (P and C) 2) Parental adjustment 3) Coping 4) Satisfaction with appearance (P and C) 5) Social experiences (C)	1) Males 3) Non-visible cleft higher social withdrawal coping style 4) Visible cleft 5) Younger adolescents	Cross-sectional questionnaire based study	Parents and children
Berger and Dalton (2011)	91 adolescents aged 11-16 with CL/P and their mothers (n=100) (same sample as above)	Strengths and Difficulties Questionnaire (P and C)	More negative social experiences Poor maternal adjustment Speech difficulties Low satisfaction with appearance Being male Social withdrawal.	Cross-sectional questionnaire based study	Parent and child

Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Nelson, O'Leary, and Weinman (2009)	42 parents of babies aged 12-24 months with CL/P	1)Hospital Anxiety and 2)Depression Scale 3)Perceived Stress Scale	1) & 3) Blame themselves for cleft	Cross-sectional, questionnaire based	Parent
Cheung, Loh, and Ho (2006)	9 CLP young adults	1)Social Avoidance and Distress Scale 2)Cultural-free Self Esteem Inventory 3)Satisfaction with Life Scale (At 12 weeks after operation)	1)Distraction osteogenesis surgery 3) Conventional jaw surgery	Longitudinal study, questionnaire based.	Young person
Chua, Ho, and Cheung (2012)	30 16-year olds with CL/P	1)Social avoidance and distress 2)Self- esteem 3)Life satisfaction	3) Conventional jaw surgery.	Prospective randomised controlled trial, questionnaire based	Young person
Feragen, Kvaem, Rumsey, and Borge (2010)		1)Depressive symptoms 2)No. of close friends 3)Social acceptance 4)Perceptions of appearance	1) CP, lower social acceptance, less attractive physical appearance 4)Girls with a visible cleft, less social acceptance	Cross-sectional correlational study, questionnaire based	Child
Cochrane and Slade (1999)	51 adults with CL or CLP	1)Positive and 2)negative affect 3)Satisfaction with life 4)Social activities and distress 5)Coping style 6)Sense of Coherence Scale 7) Appraisals of cleft	7) Male 1),2), 3) & 4) Negative appraisal of cleft	Correlational (mixed methods)	Individual



Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Feragen, Borge and Rumsey (2009)	268 10 year olds with CL/P or SMC	1)Teasing/ curiosity (P & C) 2)Satisfaction with appearance (P&C) 3)intellectual ability 4)depression 5)anxiety 6)adjustment	4),5) & 6) Children with additional difficulties 1) Less resilient 2), 4) & 5) Less resilient (C rated only)	Cross-sectional, questionnaire based	Parents and child
Richman (1983)	30 15-18 year olds with CLP with speech problems	Self-perception of educational and social participation, appearance and speech	Poor adjustment associated with low satisfaction in appearance and with education	Cross-sectional, interview and questionnaire based	Child
Richman, Holmes, and Eliason (1985)	36 14-17 year olds with CLP	Differences between self and other ratings of: 1) facial appearance (T & C) 2)Behavioural problems (C&P)	1)Higher self ratings compared to T ratings	Cross-sectional, questionnaire based	Parent Teacher Child
Feragen and Borge (2010)	661 10 and 16 year olds with CL/P	1)Satisfaction with appearance 2)Self-perception 3)Child Experience Questionnaire 4)Current/ past teasing	1)& 4)16 yr old girls 4) Visible cleft 1) High level of peer harassment	Cross sectional, questionnaire and interview based	Child Parent
Tobiasen and Hiebert (1993)	31 adolescents with CLP and their parents	1)Psychological adjustment (P) 2)Negative and 3)positive emotions (C) 4)Self-perception 5) Social competence (P)	2),3) & 4)Those who rated their impairments as more severe compared to peer ratings 5) Lower self-rated appearance	Cross-sectional, questionnaire based	Parent Child Peer ratings

Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Hunt, Burden, Hepper, Stevenson, and Johnston (2006)	160 8-21 year olds with CL/P	1)Anxiety 2)Depression 3)Self-esteem 4)Behavioural problems 5)Interview about social functioning 6)Happiness with facial appearance	1), 2), 4) & 6) Higher rates of teasing 6) Visible scar	Correlational/ Cross-sectional Questionnaire based	Child Self-report
Collett, Cloonan, Speltz, Anderka, and Werler (2012)	93 4-9 year olds with CL/P (plus control group)	Child behaviour Quality of life Social competence Parenting stress	Males and children aged 7-9 years	Cross sectional, questionnaire based	Parent Child
Coy, Speltz, and Jones (2002)	57 infants aged 3-24 months with CP or CLP and their mothers, 52 by time 2	1)Attachment – strange situation at 12 months 2)Facial attractiveness	1)Higher facial attractiveness 2) CLP	Longitudinal, observational	Observations by clinician Independent panel
Dak-Albab and Dashash (2013)	87 children with CL/P aged 6-14	Child Oral Health Related Quality of Life measure (C)	Low SES	Cross-sectional	Parent Child
Endriga, Jordan, and Speltz (2003)	31 children aged 2-7 with CLP or CP with their mothers	1)Parenting stress 2)Family environment 3)Maternal sensitivity 4)Emotional regulation 5)Child Behaviour (P)	1)and 5) correlated	Longitudinal, observational and questionnaire based	Parent Observation Child

Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Endriga, Speltz, Maris, and Jones (1998)	57 infants with CLP or CP aged 3-12 months and their mothers	Attachment – strange situation 12 months	CP Low maternal sensitivity	Longitudinal, structured observational study	Clinical observations
Kramer, Gruber, Fialka, Sinikovic, and Schliephake (2008)	147 5-6 year olds with CL/P and their families	1)Health related quality of life 2)Impact on family	2) CLP and CL	Exploratory cross-sectional study, questionnaire based.	Child Parent (Sig different)
Leonard, Brust, Abrahams, and Sielaff (1991)	105 8-18 year olds with CL/P	Piers-Harris Self-Concept Scale (C)	Adolescent girls Younger boys	Cross-sectional study, questionnaire based	Child
Marcusson, Paulin, and Östrup (2002)	68 adults with a cleft aged 19-29 (& controls)	1)Body image 2)QoL and health related QoL 3) Psychological symptoms	1) Female 2)& 3) Lower satisfaction with appearance	Questionnaire based, cross sectional and correlational study	Individual Professional panel (Sig. different)
McWilliams and Matthews (1979)	226 children with UCLP or CP with and without other congenital abnormalities. Age 4-18 years.	1)Intelligence – measured using WIPPSI, WISC or WAIS 2) Social maturity	1)CP, additional abnormalities 2) CP	Cross-sectional study, clinician rated.	Clinician Parent

Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Neiman and Savage (1997)	186 young children aged 2-36 months with CL/P. No additional syndromes.	Kent Infant Development Scale or Minnesota Child Development Inventory	CP (in expressive language tasks only)	Cross-sectional, questionnaire based	Parent
Ramstad, Ottem, and Shaw (1995)	233 adults with CLP	Asked about presence of depression, anxiety and palpitations.	Concerned about appearance and speech	Cross-sectional, questionnaire based	Individual
Slifer et al. (2003)	34 children aged 8-16 with CL/P	1) Child behaviour 2) Self-perception 3) Social Support 4) Life satisfaction (health) 5) Discomfort 6) Social Skills	4) Less satisfied with appearance (C)	Cross-sectional, correlational, questionnaire and observations	Parent Child
Speltz et al. (2000)	57 infants with CLP or CP 3-24 months	Bayley Scales of Infant Development	Low maternal feeding and teaching scores	Longitudinal study, observations and standardised assessment	Observation Parent
Starr (1980)	49 10-year olds with CL/P	Behaviour problems Self-esteem Attitude towards cleft	None found	Cross-sectional, questionnaire based	Parent Child

Study	Participants	Outcome variables/ measures	Possible risk factors related to adjustment	Type of study	Respondents
Thomas, Turner, Rumsey, Dowell, and Sandy (1997)	111 10, 15 and 20 year olds with CL/P including SMC and their parents (n=62)	1)satisfaction with facial appearance (C & P) 2)Childhood Experience Questionnaire (10 and 15yrs only)	1)10 and 15 years, visible cleft 2)Less satisfied with appearance	Cross-sectional, questionnaire based	Parent Child
Tyler, Wehby, Robbins, and Damiano (2013)	279 parents of children with CL/P	Separation anxiety	Impairments in speaking or eating, poor maternal health and lower SES.	Prevalance, questionnaire based	Parent
Wu, Chao, Lo, Chen, and Noordhoff (2000)	101 children aged 13-19 years	Social support Life adjustment	Social support linked with life adjustment	Cross-sectional	Individual

<sup>1</sup> This column lists factors that have been found to be significantly related to poorer adjustment as measured using a variety of measures. They are separated to indicate which factors are related to which particular measure of adjustment.

#### Abbreviations

CL/P: cleft lip and/ or palate; CP: cleft palate only; CL: cleft lip; SMC: sub-mucous cleft; BCL/BCLP: bilateral cleft lip/ lip and palate; UCL/UCLP: unilateral cleft lip/ lip and palate; CLP: cleft lip and palate; SES: socio-economic status; P:parent rated; C: child rated; T: teacher rated; SDQ: strengths and difficulties questionnaire; PTSD: post traumatic stress disorder; MMPI: Minnesota Multiphasic Personality Inventory; WPPSI: wechsler preschool and primary scale of intelligence; WISC: wechsler intelligence scale for children; WAIS: wechsler adult intelligence scale; FSIQ: full scale IQ score; QoL: quality of life.

**Appendix 3** Service Improvement Project: guidelines for authors from  
Dementia

*The following extract was taken from the Dementia website*

*<http://www.uk.sagepub.com/msg/dem.htm#MANUSCRIPTSTYLE> on 30<sup>th</sup>*

*September 2014*

## **9. Manuscript style**

### **9.1 File types**

Only electronic files conforming to the journal's guidelines will be accepted. Preferred formats for the text and tables of your manuscript are Word DOC, DOCX, RTF, XLS. LaTeX files are also accepted. Please also refer to additional guideline on submitting artwork [and supplemental files] below.

### **9.2 Journal Style**

*Dementia* conforms to the SAGE house style. [Click here](#) to review guidelines on SAGE UK House Style.

Lengthy quotations (over 40 words) should be displayed and indented in the text.

*Language and terminology.* Jargon or unnecessary technical language should be avoided, as should the use of abbreviations (such as coded names for conditions). Please avoid the use of nouns as verbs (e.g. to access), and the use of adjectives as nouns (e.g. demented). Language that might be deemed sexist or racist should not be used.

*Abbreviations.* As far as possible, please avoid the use of initials, except for terms in common use. Please provide a list, in alphabetical order, of abbreviations used, and spell them out (with the abbreviations in brackets) the first time they are mentioned in the text.

### **9.3 Reference Style**

*Dementia* adheres to the APA reference style. [Click here](#) to review the guidelines on APA to ensure your manuscript conforms to this reference style.

### **9.4. Manuscript Preparation**

The text should be double-spaced throughout with generous left and right-hand margins. Brief articles should be up to 3000 words and more substantial articles between 5000 and 8000 words (references are not included in this word limit). At their discretion, the Editors will also consider articles of greater length. Innovative practice papers should be between 750-1500 words.

#### **9.4.1 Keywords and Abstracts: Helping readers find your article online**

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on [How to Help Readers Find Your Article Online](#). The abstract should be 100-150 words, and up to five keywords should be supplied in alphabetical order.

#### **9.4.2 Corresponding Author Contact details**

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

#### **9.4.3 Guidelines for submitting artwork, figures and other graphics**

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's [Manuscript Submission Guidelines](#).

Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour

reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

#### **9.4.4 Guidelines for submitting supplemental files**

This journal is able to host approved supplemental materials online, alongside the full-text of articles. Supplemental files will be subjected to peer-review alongside the article. For more information please refer to SAGE's [Guidelines for Authors on Supplemental Files](#).

#### **9.4.5 English Language Editing services**

Non-English speaking authors who would like to refine their use of language in their manuscripts might consider using a professional editing service. Visit [English Language Editing Services](#) for further information.



## An evaluation of the Alzheimer's Cafés in Wiltshire

### What is this all about?

As you may know, the Alzheimer's Cafés have been running for around three years in Wiltshire. Alzheimer's Support asked me to find out what is helpful about attending these cafés and what you would like to see change in the future.

### How did I do this?

I met with a group of volunteers who attend the Alzheimer's Café in Westbury and also interviewed two people who attend the café in East Grafton.

### What did they say?

They told me that there were some very helpful things about attending these cafes:

- They felt very welcome and liked being greeted at the door by a volunteer
- They liked to opportunity to socialise with other people who are in the same position as them and to share ideas with each other. This was often seen as the most helpful part of the café.
- Those attending the Westbury café liked having professionals available to talk to outside of the clinic setting.
- Some people found the talks helpful, in particular those that gave clear advice or that talked about how it feels to have dementia or to be caring for someone with dementia.

They also made some great suggestions about how things could be changed in the future:

- Have a bit longer at the end to socialise with other families and more opportunities to mix people up so you can talk to different people
- Some said it might be helpful for volunteers to make sure everyone on a table is introduced to each other
- Perhaps have a few music evenings at the Westbury café rather than live music every session as it can be hard to talk over the music
- Some felt that it would be good to have more opportunities to feed back on the cafes, in particular to feed back on the talks.

### What now?

These results are now going to be fed back to Alzheimer's Support so they can think about what you have told me. I am sure that they would be happy to be contacted directly if you have any other feedback you would like to give them.

### Acknowledgements

Thank you to all of you who volunteered to take part in this evaluation and also to all of the staff and volunteers from Alzheimer's Support who have been very supportive of this project.

**Appendix 5** Main Research Project – guidance for authors for The Cognitive Behaviour Therapist

*The following extract was taken from the Cognitive Behaviour Therapist website  
[http://assets.cambridge.org/CBT/CBT\\_ifc.pdf](http://assets.cambridge.org/CBT/CBT_ifc.pdf) on 30th September 2014*

## Style Guide

- **Title page.** The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated.
- **Abstract.** The abstract should include up to six key words that could be used to describe the article. This should summarize the article in no more than 250 words, references should not to be included in the abstract.
- **All articles must include a set of 3-5 learning objectives** that will be achieved through reading the paper. At the end of each paper a summary of the main points from the paper must be included with suggestions for follow-up reading. This stipulation is in keeping with the practitioner and professional development aims of the journal.
- **Text.** This should begin with an introduction, succinctly introducing the point of the paper to those interested in the general area of the journal. Attention should be paid to the Editorial Statement. References within the text should be given in the form of (Jones & Smith, 1973). When there are three or more authors the first citation should be given as Williams et al. (1973). The appropriate positions of tables and figures should be indicated in the text. Footnotes should be avoided where possible.
- **References** should be in the APA style. All citations in the text should be listed in strict alphabetical order according to surnames. Multiple references to the same author should be listed using a, b, etc., for entries within the same year. Note: Authors are encourages to include digital object identifiers (dois) in their citation listings, as follows:  
  
Kaltenthaler, E., Parry, G. and Beverley, C. (2004). Computerised cognitive behaviour therapy: a systematic review. *Behavioural and Cognitive Psychotherapy*, 32, 31–55. doi:10.1017/S135246580400102X.
- **Declaration of interests** should be included with all papers, if there are none this should be stated.
- **Acknowledgements.** May include previous unpublished presentations (e.g. dissertation, meeting paper), financial support, scholarly or technical assistance etc.
- **Tables.** Tables should be numbered and given explanatory titles.

## **Appendix 6** Main Research Project: Outline of original study design and recruitment strategy

### Intended design

This research was initially designed as a prospective study with pre and post measures administered before and after therapy.

Power calculations indicated that 21 therapist and client dyads needed to be recruited. Ideally this would have been 21 therapists and 21 clients however difficulties with recruitment and a reluctance of local services to take part meant that the actual number recruited was lower (8 therapists and 17 clients).

The original design involved therapists completing the same measures (see table below). Clients were asked to complete measures of interpersonal difficulties both before and after therapy to see if there was any change in interpersonal difficulties over time (hence controlling for any impact therapy itself may have had on interpersonal skills). They were also asked to complete the attachment measure before therapy and the therapeutic relationship measure after therapy/ eight sessions (whichever came sooner). Initially, we were hoping to ask therapists and clients to complete the brief ARM-5 after every session, however many therapists we approached felt this was too much so it was reduced to the longer version administered once after therapy.

This table lists the measures used in the initial prospective design:

	Client	Therapist
Before commencing treatment	<i>PHQ-9</i> <i>GAD-7</i> Inventory of Interpersonal Problems (IIP-32) Attachment Style Questionnaire Demographic Information	Attachment Style Questionnaire
After six - eight sessions of CBT	<i>PHQ-9</i> <i>GAD-7</i> Agnew Relationship Measure IIP- 32	Agnew Relationship Measure Progress in Interpersonal Problems

Four clients were recruited into the prospective study, one of whom completed both pre and post measures. The others did not send back their post therapy measures, despite a reminder being sent. This is why for the client rated therapeutic relationship measures there were only 14 included in the analyses, not 17 as for every other client measure.

However, as time was passing it was decided to move to a cross-sectional study and include these four clients as part of the revised study. This did seem to improve uptake as therapists no longer had to remember to raise the study with their clients at the first meeting and instead could do this later on. It was also easier for therapists to identify a number of people on their caseload who were approaching or had already had eight sessions of CBT, rather than wait for new referrals. It also meant that clients only had to complete and return one set of questionnaires reducing attrition rates.

There were some downsides to this too. One was that the clients who dropped out of therapy could not be included in the pre therapy measures and differences between those who dropped out and those who remained in therapy could not be explored. Secondly, therapists were then selecting the clients that they approached.

### Process of recruitment

A number of measures were used to recruit therapists into the study and to help remind them to approach their clients. Firstly, course staff approached local services on my behalf to identify clinicians who might be willing to help. As many local IAPT services were at that time undergoing service changes this meant that many clinicians felt unable to help out due to job uncertainty. I then approached IAPT services that I had worked in previously in London and members of the course team also approached any out of area services that they were connected with. Finally, I also contacted IAPT services across South West England.

When secondary care services were approached initially they reported that their client group was too complex to use CBT and therefore they felt their services would not be appropriate for this research.

The CBT therapists working in student services were contacted and emails were also sent to all the BABCP accredited therapists in the Bristol and Bath area. Finally, I also made contact with the primary care psychology services in Guernsey and my supervisor and Stephen Barton spoke with IAPT teams, the local DClinPsy course team and private therapists in Newcastle.

Reasons for not taking part included reservations about asking clients and therapists to complete additional measures, that other trainees were conducting research there already and concerns about increasing staff workloads . Some therapists did not feel they were conducting 'proper CBT'.

Once therapists had indicated that they were interested in taking part (24 therapists expressed an interest in total) I initially either met with them (or their teams) or spoke with them over the phone. After this I maintained contact via email and sent regular reminders about the research project. As much as possible the consistency of these reminders was agreed with therapists in advance. For one IAPT team, for example, I met with the whole team on two occasions and the service manager once as well as sending reminder emails to all the therapists who had agreed to take part on a fortnightly basis.

## **Appendix 7 Main Research Project: Client participant information sheet**



### **Patient Information Sheet**

Title: Interpersonal style and therapeutic alliance in cognitive behaviour therapy

Researcher: Corin Le Huray, Trainee Clinical Psychologist, University of Bath

Version and date: Version 4 19.05.14

**We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.**

**Talk to others about the study if you wish.**

**Part 1 tells you the purpose of the study and what you will be asked to do if you decide to take part.**

**Part 2 gives you more detailed information about the conduct of the study.**

**Please ask if there is anything that is unclear.**

#### What is this all about?

It is really important that treatments offered in the NHS are effective for as many people as possible. This project aims to find out if the way the client and therapist relate to other people (their interpersonal style) has an impact on the relationship clients have with their therapists and on the outcome of cognitive behaviour therapy (CBT).

#### Why me?

You have been invited as you have been referred for CBT. We are hoping that about 20 people will be involved in the research in total.

#### Do I have to take part?

No, it is up to you to decide to join the study. If you agree to take part we will ask you to sign a consent form. You are free to drop out at any time, without giving a reason. Whatever you decide, it will not impact in any way on the treatment you will receive.



### What will I be asked to do?

If you would like to take part in this research, you will be asked to complete some questionnaires after eight CBT sessions or at the end of treatment, whichever comes sooner.

This is in addition to any questionnaires that are routinely used by the service you are being seen in. You will also be asked for your consent for the researcher to have access to your scores on these measures too.

You will be contacted by a researcher who will offer to either meet with you to complete the questionnaires or can send them to you in the post with a stamped addressed envelope. These will take you about 25 minutes.

Your therapist is also participating in the study and will also be completing questionnaires after eight sessions asking about how they feel the therapy is going.

### What are the possible disadvantages to taking part?

One disadvantage is the time taken to complete the questionnaires (25 minutes).

### What are the possible benefits of taking part?

All participants will receive a £5 Amazon voucher to thank them for their time.

### Will my information be confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The only time this confidentiality would be broken is if we were concerned about harm coming to you or to someone else. More details are included in part two.

## **Part Two**

### What will happen if I don't want to carry on with the study?

If you decide to drop out of the study, this will not impact on your treatment. If you have already sent us some questionnaires then these might still be included in the research.

### What if there is a problem?

If you have a concern about any aspect of this study or wish to make a complaint you can contact Claire Lomax, Clinical Research Tutor at the University of Bath, on 01225 385091.

### What happens to the questionnaires after I have completed them?

The researcher will collect the information together and input it all into a database. This database will not contain any information that might identify you. The questionnaires will be destroyed securely once they are no longer needed for research purposes. Only the researcher named above will have access to identifiable data.

Your clinician will know that you are taking part in the research but will not be able to see any of the answers you gave to the questionnaires, apart from those you complete with them in your sessions.

### What will happen to the results of the research study?

The responses to all the questionnaires will be collated together to look for any patterns. The results will be submitted for publication but will not include any information that could identify anyone who took part in the research. If you would like to receive a summary of the results you can indicate this on your consent form.

### Who is funding this research?

This project is being undertaken as part of a professional doctoral qualification at the University of Bath.

### Who has reviewed this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by an NHS Research Ethics Committee.

### Who can I contact for more information?

You can call the University of Bath research phone line at any time. The number is 01225 385745. Please leave a voicemail stating your name and contact details as well as the name of the researcher you are trying to contact (Corin Le Huray). Alternatively you can email Corin on [c.le.huray@bath.ac.uk](mailto:c.le.huray@bath.ac.uk).

## **Appendix 8 Main Research Project: Therapist information sheet**



### **Therapist Information Sheet**

Title: Interpersonal style and therapeutic alliance in Cognitive Behaviour Therapy (CBT)

Researcher: Corin Le Huray, Trainee Clinical Psychologist, University of Bath

Version and date: Version 3 19.05.14

**We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.**

**Talk to others about the study if you wish.**

**Part 1 tells you the purpose of the study and what you will be asked to do if you decide to take part.**

**Part 2 gives you more detailed information about the conduct of the study.**

**Please ask if there is anything that is unclear.**

#### What is this all about?

Previous research has shown that the client's interpersonal style can impact on the effectiveness of CBT for people with depression and that this may be mediated by the therapeutic relationship (Hardy et al., 2001). Many of these studies have strict eligibility criteria and only include those having treatment for depression (Renner et al., 2012). This study aims to find out whether similar findings are observed in a 'typical' sample of people referred for CBT in primary and secondary care psychology services.

Research has also been conducted looking at the impact of the therapist's interpersonal style on the development of an effective therapeutic relationship (Black, Hardy, Turpin, & Parry, 2005). This study aims to extend this research by investigating whether the degree of similarity between the therapist's and the client's interpersonal styles impacts on the development of the therapeutic relationship and the effectiveness of CBT.

Finally, it aims to investigate which interpersonal difficulties are discussed in therapy and which improve over time. This has been investigated in Interpersonal Psychotherapy but not yet in CBT (Horowitz, Rosenberg, & Bartholomew, 1993).

### Why me?

You have been invited to take part as you are offering CBT within a primary or secondary care setting.

### What will I be asked to do?

If you would like to take part in this research, you will be asked to:

- 1) Ask clients that you have taken on for CBT to see if they are happy to be contacted by a researcher and give them a copy of the Participant Information Sheet. These clients need to have scored 5 or above on the PHQ-9 at the start of treatment.
- 2) Complete a questionnaire asking about your interpersonal style which will take about 10 minutes and will remain confidential. You only need to do this once, not for every client who is involved in the research project.
- 3) After eight sessions of CBT you will be asked to complete two questionnaires. One asks about the therapeutic relationship and the second asks you tick items from a short list of interpersonal problems to indicate which were discussed in therapy and which you feel have improved for the client.
- 4) Share the results obtained from routine outcome measures with the researcher with the client's consent.

Your clients will be asked to:

- 1) Complete measures asking them their interpersonal style and how they feel the therapy is going.
- 2) Give permission for the researcher to access their scores on routine outcome measures administered by the clinician to measure their mood and level of anxiety.

### Do I have to take part?

No, it is up to you to decide to join the study. If you agree to take part we will ask you to sign a consent form. You are free to drop out at any time, without giving a reason.

### What are the possible disadvantages to taking part?

One disadvantage is the time taken to complete the questionnaires (10 minutes to complete the initial questionnaire and 15 minutes to complete the two questionnaires after eight sessions of CBT).

### What are the possible benefits of taking part?

Completing measures can be a helpful way of reflecting on the development of the therapeutic relationship.

### Will my information be confidential?

Yes. Your responses to the questionnaires will remain confidential and will not be shared with the client or anyone else. Likewise, we will not be able to share your client's responses with you.

## **Part Two**

### What will happen if I don't want to carry on with the study?

If you decide to drop out of the study, your clients will still be asked to complete their questionnaires. If you have already sent us some questionnaires then these will still be included in the research.

### What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (see below for contact details). If during the course of this research any concerns were raised about the standard of therapy offered, then these will be acted on.

### What happens to the questionnaires after I have completed them?

The researcher will collect the information together and input it all into a database. This database will not contain any information that might identify you. The questionnaires will be destroyed securely once they are no longer needed for research purposes. Only the researcher named above will have access to identifiable data.

### What will happen to the results of the research study?

The responses to all the questionnaires will be collated together to look for any patterns. The results will be submitted for publication but will not include any information that could identify anyone who took part in the research, therapists or clients. It will be possible to meet with the researcher following the study to discuss the results and clinical implications.

### Who is funding this research?

This project is being undertaken as part of a professional doctoral qualification at the University of Bath.

### Who has reviewed this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by an NHS Research Ethics Committee.

Who can I contact for more information?

You can call the University of Bath research phone line at any time. The number is 01225 385745. Please leave a voicemail stating your name and contact details as well as the name of the researcher you are trying to contact (Corin Le Huray). Alternatively you can email Corin on [c.le.huray@bath.ac.uk](mailto:c.le.huray@bath.ac.uk).

**Appendix 9** Main Research Project: Letter outlining NHS ethical approval for original study



## **Health Research Authority**

### **NRES Committee South West - Cornwall & Plymouth**

Bristol Research Ethics Committee Centre  
Level 3  
Block B  
Whitefriars  
Lewins Mead  
Bristol  
BS1 2NT

Telephone: 01173421390 Facsimile: 01173420445

07 February 2014

Ms Corin Le Huray  
Trainee Clinical Psychologist  
Taunton and Somerset NHS Foundation Trust  
Clinical Psychology  
Department of Psychology  
University of Bath, Claverton Down  
BA2 7AY

Dear Ms Le Huray

<b>Study Title:</b>	<b>Interpersonal styles and therapeutic alliance in Cognitive Behaviour Therapy</b>
<b>REC reference:</b>	<b>14/SW/0009</b>
<b>Protocol number:</b>	<b>N/A</b>
<b>IRAS project ID:</b>	<b>120562</b>

Thank you for your letter of 6<sup>th</sup> February 2014 responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Georgina Castledine, [nrescommittee.southwest-cornwall-plymouth@nhs.net](mailto:nrescommittee.southwest-cornwall-plymouth@nhs.net).

#### **Confirmation of ethical opinion**



On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

### **Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made.

Guidance on where to register is provided within IRAS.

**You must notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### **Approved documents**

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter	Letter from Corin Le Huray	12 November 2013
Evidence of insurance or indemnity	Professional Indemnity	15 July 2013
Investigator CV	Corin Le Huray	12 November 2013
Letter from Sponsor		18 October 2013
Other: Supervisor CV	Claire Lomax	13 November 2013
Participant Consent Form: Client	2	11 October 2013
Participant Consent Form: Therapist	1	23 October 2013
Participant Information Sheet: Client	2	11 October 2013
Participant Information Sheet: Therapist	1	23 October 2013
Protocol	1	13 November 2013
Questionnaire: Validated Questionnaire Pack		
REC application	120562/5277 48/1/535	13 November 2013
Referees or other scientific critique report		13 November 2013
Covering Letter	Letter from Corin Le Huray	12 November 2013
Evidence of insurance or indemnity	Professional Indemnity	15 July 2013

Investigator CV	Corin Le Huray	12 November 2013
Letter from Sponsor		18 October 2013
Other: Supervisor CV	Claire Lomax	13 November 2013
Participant Consent Form: Client	3	11 October 2013
Participant Consent Form: Therapist	2	23 October 2013
Participant Information Sheet: Client	3	11 October 2013
Participant Information Sheet: Therapist	2	23 October 2013
Protocol	1	13 November 2013
Covering Letter		

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### **After ethical review**

#### Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

<b>13/SW/0335</b>	<b>Please quote this number on all correspondence</b>
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'PP. Ainsworth-Smith', with a stylized flourish at the end.

**Ian Ainsworth-Smith**  
**Chair**

Email: [nrescommittee.southwest-cornwall-plymouth@nhs.net](mailto:nrescommittee.southwest-cornwall-plymouth@nhs.net)

Enclosures:                    *“After ethical review – guidance for researchers” [SL-AR2]*

Copy to:                        *Mr Sean Scott*

*Dr Kirstie Anderson, Newcastle upon Tyne Hospitals  
NHS Foundation Trust  
Sean Scott, Newcastle upon Tyne Hospitals NHS Foundation Trust*

**Appendix 10** Main Research Project: Letter from NHS Ethics regarding approval for minor amendment



**Health Research Authority**  
**NRES Committee South West - Cornwall & Plymouth**

Level 3  
Block B  
Whitefriars  
Lewins Mead  
Bristol  
BS1 2NT

Tel: 01173421390  
Fax: 01173420445

22 May 2014

Ms Corin Le Huray  
Trainee Clinical Psychologist  
Taunton and Somerset NHS Foundation Trust  
Clinical Psychology  
Department of Psychology  
University of Bath, Claverton Down  
BA2 7AY

Dear Ms Le Huray

<b>Study title:</b>	<b>Interpersonal styles and therapeutic alliance in Cognitive Behaviour Therapy</b>
<b>REC reference:</b>	<b>14/SW/0009</b>
<b>Protocol number:</b>	<b>N/A</b>
<b>Amendment number:</b>	<b>MA1</b>
<b>Amendment date:</b>	<b>19 May 2014</b>
<b>IRAS project ID:</b>	<b>120562</b>

Thank you for your letter of 19 May 2014, notifying the Committee of the above amendment.

The Committee does not consider this to be a “substantial amendment” as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

**Documents received**

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper		19 May 2014
Notice of Minor Amendment		19 May 2014
Participant information sheet (PIS) [Therapist]	4	19 May 2014
Participant information sheet (PIS)	4	19 May 2014

A Research Ethics Committee established by the Health Research Authority

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

<b>14/SW/0009:</b>	<b>Please quote this number on all correspondence</b>
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Yours sincerely



**Miss Georgina Castledine REC Assistant**

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*Copy to: Professor Jane Millar*

A Research Ethics Committee established by the Health Research Authority

## Appendix 11 Main Research Project: PHQ-9 and GAD-7

<b>PHQ-9</b> Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

<b>GAD-7</b> Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3



## Appendix 12 Main Research Project: Inventory of Interpersonal Problems

Here is a list of problems that people report in relating to others. Please read the list below, and for each item, circle the number that best describes you.

### **PART I** The following are things you find hard to do with other people.

It is hard for me to:	Not at all	A little bit	Mod- erately	Quite a bit	Extre- mely
1. join in on groups	0	1	2	3	4
2. be assertive with another person	0	1	2	3	4
3. make friends	0	1	2	3	4
4. disagree with other people	0	1	2	3	4
5. make a long-term commitment to another person	0	1	2	3	4
6. be aggressive towards another person when the situation calls for it	0	1	2	3	4
7. socialize with other people	0	1	2	3	4
8. show affection to people	0	1	2	3	4
9. feel comfortable around other people	0	1	2	3	4
10. tell personal things to other people	0	1	2	3	4
11. be firm when I need to be	0	1	2	3	4
12. experience a feeling of love for another person	0	1	2	3	4
13. be supportive of another person's goals	0	1	2	3	4
14. really care about other people's problems	0	1	2	3	4
15. put somebody else's needs before my own	0	1	2	3	4
16. take instructions from people who have authority over me	0	1	2	3	4
17. open up and tell my feelings to another person	0	1	2	3	4
18. attend to my own welfare when somebody else is needy	0	1	2	3	4
19. be involved with another person without feeling trapped	0	1	2	3	4

**PART II The following are things that you do too much:**

	Not at all	A little bit	Moder- ately	Quite a bit	Extr- emely
20. I fight with other people too much	0	1	2	3	4
21. I get irritated or annoyed too easily	0	1	2	3	4
22. I want people to admire me too much	0	1	2	3	4
23. I am too dependent on other people	0	1	2	3	4

	Not at All	A little bit	Moder- ately	Quite a bit	Extre- mely
24. I open up to people too much	0	1	2	3	4
25. I put other people's needs before my own too much	0	1	2	3	4
26. I am overly generous to other people	0	1	2	3	4
27. I worry too much about other people's reactions to me	0	1	2	3	4
28. I lose my temper too easily	0	1	2	3	4
29. I tell personal things to other people too much	0	1	2	3	4
30. I argue with other people too much	0	1	2	3	4
31. I am too envious and jealous of other people	0	1	2	3	4
32. I am affected by another person's misery too much	0	1	2	3	4

## Appendix 13 Main Research Project: Attachment Style Questionnaire

For the next few questions, show how much you agree with each of the following items by rating them on this scale:

Totally Disagree <b>1</b>	Strongly Disagree <b>2</b>	Slightly Disagree <b>3</b>	Slightly Agree <b>4</b>	Strongly Agree <b>5</b>	Totally Agree <b>6</b>
Overall, I am a worthwhile person.					
				1	2 3 4 5 6
I am easier to get to know than most people.					
				1	2 3 4 5 6
I feel confident that other people will be there for me when I need them.					
				1	2 3 4 5 6
I prefer to depend on myself rather than other people.					
				1	2 3 4 5 6
I prefer to keep to myself.					
				1	2 3 4 5 6
To ask for help is to admit that you're a failure.					
				1	2 3 4 5 6
People's worth should be judged by what they achieve.					
				1	2 3 4 5 6
Achieving things is more important than building relationships.					
				1	2 3 4 5 6
Doing your best is more important than getting on with others.					
				1	2 3 4 5 6
If you've got a job to do, you should do it no matter who gets hurt.					
				1	2 3 4 5 6
It's important that others like me.					
				1	2 3 4 5 6
It's important to me to avoid doing things that others won't like					
				1	2 3 4 5 6
I find it hard to make a decision unless I know what other people think.					
				1	2 3 4 5 6
My relationships with others are generally superficial.					
				1	2 3 4 5 6
Sometimes I think I am no good at all.					
				1	2 3 4 5 6
I find it hard to trust other people.					
				1	2 3 4 5 6
I find it difficult to depend on others.					
				1	2 3 4 5 6
I find that others are reluctant to get as close as I would like.					
				1	2 3 4 5 6
I find it relatively easy to get close to other people.					
				1	2 3 4 5 6
I find it easy to trust others.					
				1	2 3 4 5 6
I feel comfortable depending on other people					
				1	2 3 4 5 6

Totally Disagree	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree	Totally Agree
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>

I worry that others won't care about me as much as I

care about them

**1 2 3 4 5 6**

I worry about people getting too close

**1 2 3 4 5 6**

I worry that I won't measure up to other people

**1 2 3 4 5 6**

I have mixed feelings about being close to others

**1 2 3 4 5 6**

While I want to get close to others, I feel uneasy about it.

**1 2 3 4 5 6**

I wonder why people would want to be involved with me.

**1 2 3 4 5 6**

It's very important to me to have a close relationship.

**1 2 3 4 5 6**

I worry a lot about my relationships.

**1 2 3 4 5 6**

I wonder how I would cope without someone to love me.

**1 2 3 4 5 6**

I feel confident about relating to others.

**1 2 3 4 5 6**

I often feel left out or alone

**1 2 3 4 5 6**

I often worry that I do not really fit in with other people

**1 2 3 4 5 6**

Other people have their own problems, so I don't bother  
them with mine

**1 2 3 4 5 6**

When I talk over my problems with others, I generally  
feel ashamed or foolish.

**1 2 3 4 5 6**

I am too busy with other activities to put much time  
into relationships

**1 2 3 4 5 6**

If something is bothering me, others are generally aware  
and concerned.

**1 2 3 4 5 6**

I am confident that other people will like and respect me.

**1 2 3 4 5 6**

I get frustrated when others are not available when I need  
them.

**1 2 3 4 5 6**

Other people often disappoint me.

**1 2 3 4 5 6**

## Appendix 14 Main Research Project: Agnew Relationship Measure client and therapist version

### Client version

Please think about your therapy sessions and rate the following items using the scale below:

1	2	3	4	5	6	7
Strongly disagree			Neither agree or disagree			Strongly agree
I feel free to express the things that worry me.	1	2	3	4	5	6 7
I feel friendly towards my therapist.	1	2	3	4	5	6 7
I am worried about embarrassing myself with my therapist.	1	2	3	4	5	6 7
I take the lead when I'm with my therapist.	1	2	3	4	5	6 7
I keep some important things to myself, not sharing them with my therapist.	1	2	3	4	5	6 7
I have confidence in my therapist and his/her techniques.	1	2	3	4	5	6 7
I feel optimistic about my progress.	1	2	3	4	5	6 7
I feel I can openly express my thoughts and feelings to my therapist.	1	2	3	4	5	6 7
I feel critical or disappointed in my therapist.	1	2	3	4	5	6 7
I can discuss personal matters I am ordinarily ashamed or afraid to reveal.	1	2	3	4	5	6 7
I look to my therapist for solutions to my problems.	1	2	3	4	5	6 7
My therapist's professional skills are impressive	1	2	3	4	5	6 7
My therapist accepts me <b>no</b> matter what I say or do.	1	2	3	4	5	6 7
My therapist tries to influence me in ways that are not beneficial for me	1	2	3	4	5	6 7
My therapist finds it hard to understand me	1	2	3	4	5	6 7
My therapist is warm and friendly with me	1	2	3	4	5	6 7
My therapist does not give me the guidance I would like	1	2	3	4	5	6 7
My therapist is a persuasive person	1	2	3	4	5	6 7
My therapist is supportive	1	2	3	4	5	6 7
My therapist follows his/her own plans, ignoring my views of how to proceed	1	2	3	4	5	6 7
My therapist is confident in him/herself and his/her techniques	1	2	3	4	5	6 7
My therapist seems bored or impatient with me	1	2	3	4	5	6 7

1	2	3	4	5	6	7
Strongly disagree			Neither agree or disagree		Strongly agree	

My therapist expects me to take responsibility rather than be dependent on him/her	1	2	3	4	5	6	7
My therapist and I are willing to work hard together	1	2	3	4	5	6	7
I take the lead and my therapist expects it of me	1	2	3	4	5	6	7
My therapist and I agree about how to work together	1	2	3	4	5	6	7
My therapist and I have difficulty working jointly as a partnership	1	2	3	4	5	6	7
My therapist and I are clear about our roles and responsibilities when we meet	1	2	3	4	5	6	7

Therapist version

**Thinking about your work with this particular client. Please rate each of the items below on the following scale:**

1	2	3	4	5	6	7
Strongly disagree			Neither agree or disagree		Strongly agree	
My client feels free to express the things that worry her/him.	1	2	3	4	5	6 7
My client is friendly towards me.	1	2	3	4	5	6 7
My client is worried about embarrassing her/himself with me.	1	2	3	4	5	6 7
My client takes the lead when she/he is with me.	1	2	3	4	5	6 7
My client keeps some important things to her/himself, not sharing them with me	1	2	3	4	5	6 7
My client has confidence in me and my techniques.	1	2	3	4	5	6 7
My client feels optimistic about her/his progress.	1	2	3	4	5	6 7
My client feels he/ she can openly express her/ his thoughts and feelings to me	1	2	3	4	5	6 7
My client is critical or disappointed in me	1	2	3	4	5	6 7
My client can discuss personal matters she/he is ordinarily ashamed of or afraid to reveal	1	2	3	4	5	6 7
My client looks to me for solutions to her/his problems.	1	2	3	4	5	6 7
My professional skills are impressive to my client.	1	2	3	4	5	6 7
I accept my client no matter what she/he does.	1	2	3	4	5	6 7
I try to influence my client in ways that are not beneficial to him/her	1	2	3	4	5	6 7
I find it hard to understand my client	1	2	3	4	5	6 7
I feel warm and friendly with my client.	1	2	3	4	5	6 7
I do not give my client the guidance she/he would like.	1	2	3	4	5	6 7
I feel I am a persuasive person.	1	2	3	4	5	6 7
I feel supportive.	1	2	3	4	5	6 7
I follow my own plans, ignoring the client's view of how to proceed	1	2	3	4	5	6 7
I feel confident in myself and my techniques.	1	2	3	4	5	6 7
I feel bored or impatient with my client.	1	2	3	4	5	6 7

1	2	3	4	5	6	7
Strongly disagree			Neither agree or disagree		Strongly agree	

I expect my client to take responsibility rather than being dependent on me

1 2 3 4 5 6 7

My client and I are willing to work hard together.

1 2 3 4 5 6 7

My client takes the lead, and I expect it of her/him.

1 2 3 4 5 6 7

My client and I agree about how to work together.

1 2 3 4 5 6 7

My client and I have difficulty working jointly as a partnership.

1 2 3 4 5 6 7

My client and I are clear about our roles and responsibilities when we meet

1 2 3 4 5 6 7



**Appendix 15** Main Research Project: Client participant Demographic  
Information Sheet



Demographic Information Sheet

Name:
Address:
Phone Number:
Email:
How would you prefer to be sent your £5 gift voucher? (Please circle)  Email      Post
Age: (please circle)  18-25/ 26-35/ 36-45/ 45-55/ 56-65/ 65 upwards
Gender: Male/ Female
Are you currently taking any anti-depressant medication? Yes/No
How long have you been feeling depressed/ anxious?  Less than 2 months/ 2-6 months/ 6 months – 1 year/ over a year
Have you experienced depression in the past?  Yes/No
If so, how many times have you experienced depression in the past?  Once/ Twice/ 3-5 times/ More than 5 times

Would you like to receive a summary of the results of this research? Yes/ No (please circle) Thank you.